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The Massachusetts Medical Society

PROCEEDINGS OF THE COUNCIL

STATED MEETING, FEBRUARY 1, 1928

A Stated Meeting of the Council was held in John Ware Hall, Boston Medical Library, February 1, 1928, at 12 o'clock, noon. The President, Dr. John M. Birnie of Springfield, was in the chair and the following 112 Councilors present:

BARNSTABLE
W. D. Kinney

BERKSHIRE
A. P. Merrill

BRISTOL NORTH
F. H. Dunbar
W. H. Allen
F. A. Hubbard

BRISTOL SOUTH
P. E. Truesdale
E. F. Cody
D. J. Fennelly

ESSEX NORTH
A. M. Hubbell
E. S. Bagnall
J. F. Burnham
F. S. Smith
F. W. Snow

ESSEX SOUTH
J. A. Bedard
F. W. Baldwin
J. F. Donaldson
W. T. Hopkins
P. P. Johnson
J. F. Jordan
C. H. Phillips
R. E. Stone

HAMPDEN
J. M. Birnie
A. J. Douglas
E. A. Knowlton
A. G. Rice
J. P. Schneider

HAMPSHIRE
E. D. Williams

MIDDLESEX EAST
I. W. Richardson
R. R. Stratton

MIDDLESEX NORTH
J. H. Lambert
J. A. Mehan
T. A. Stamas

MIDDLESEX SOUTH
E. A. Andrews
E. H. Bigelow
W. T. Burke
W. H. Crosby
D. F. Cummings
C. B. Fuller
Edward Mellus
C. E. Mongan
J. P. Nelligan
J. W. Seaver
C. H. Staples
E. H. Stevens
H. W. Thayer

NORFOLK
M. H. A. Evans
D. N. Blakely
F. A. Bragg
W. L. Burrage
Samuel Crowell
F. P. Denny
D. G. Eldridge
J. B. Hall
A. H. Hodgdon
E. B. Lane
W. A. Lane
S. F. McKeen
Victor Safford
H. F. R. Watts
P. R. Withington

NORFOLK SOUTH
D. A. Bruce
C. S. Adams
T. B. Alexander
C. A. Sullivan
N. R. Pillsbury

PLYMOUTH
J. P. Shaw
C. H. Colgate
G. A. Moore
J. J. McNamara
A. C. Smith

SUFFOLK
E. P. Joslin
F. G. Balch
J. W. Bartol
Horace Binney
David Cheever
A. L. Chute
R. C. Cochrane
F. J. Cotton
W. P. Cross
W. H. Ensworth
G. B. Fenwick
R. B. Greenough
G. A. Leland
R. H. Miller
T. J. O'Brien
R. B. Osgood
J. J. Skirball
C. M. Smith
Robert Soutter
J. S. Stone
W. T. S. Thorndike
E. W. Taylor
R. H. Vose
Conrad Wesselhoeft

WORCESTER
F. H. Washburn
W. P. Bowers
L. R. Bragg
W. J. Delahanty
G. A. Dix
G. E. Emery
M. F. Fallon
Homer Gage
R. W. Greene
David Harrower
A. G. Hurd
A. W. Marsh
L. C. Miller
E. H. Trowbridge
R. P. Watkins
S. B. Woodward

WORCESTER NORTH
A. F. Lowell
W. E. Currier

The minutes of the last meeting were read by the Secretary in abstract and, as no corrections or omissions were noted they were accepted as read and as printed in the Proceedings in the *Journal*. Dr. W. T. S. Thorndike, Chairman, read a report of progress for the Committee of Arrangements for the Annual Meeting in Worcester, next June. (See Appendix No. 1.) The report was accepted. Dr. D. N. Blakely, Chairman, read the report of the Committee on Membership and Finance, on Membership, and it was accepted and its recommendations adopted.

REPORT OF COMMITTEE ON MEMBERSHIP AND FINANCE, ON MEMBERSHIP

The Committee on Membership and Finance makes the following recommendations as to membership:

1. That the following named five Fellows be allowed to retire under the provisions of Chapter I, Section 5, of the By-Laws:

1. Bruce, John Angus, Everett.
2. Bulfinch, George Greenleaf, Brookline.
3. Call, Emma Louisa, Cambridge.
4. Haskins, Solomon Foot, Cotuit.
5. Tobey, George Loring, Clinton.

2. That the dues for 1928 of the following named four Fellows be remitted under the provisions of Chapter I, Section 6, of the By-Laws:

1. Bush, Arthur Dermont, Decatur, Georgia.
2. Parker, George Leonard, Philadelphia.

3. Ruble, Wells Allen, Watford, Herts, England.
4. Wilder, Edward Wheeler, Madura, South India.

3. That the following named six Fellows be allowed to resign, as of December 31, 1927, under the provisions of Chapter I, Section 7, of the By-Laws:

1. Baker, Lewis Forrester, Lewiston, Maine.
2. Brennan, Thomas Joseph, Manila, P. I.
3. Hawley, Ralph Ernest Dudley, Nahant.
4. Parsons, Frank Sears, Dorchester.
5. Pattrell, Arthur Ellis, Towson, Maryland.
6. Zeckwer, Isolde Therese, Philadelphia.

4. That the following named nine Fellows be deprived of the privileges of fellowship, under the provisions of Chapter I, Section 8, (a) and (b), of the By-Laws:

1. Andrews, Sumner Cheever, Cambridge.
2. Bogusz-Wlazlo, Ladislaus, Detroit, Michigan.
3. Claffy, John McMahon, Gambrills, Maryland.
4. Lyman, William Robinson, Dowagiac, Michigan.
5. MacGregor, George Gleason, Dade City, Florida.
6. McLellan, William Edwin, Buffalo, New York.
7. Newton, William Curtis, San Diego, California.
8. Polak, Isaac Benjamin, U. S. Navy.
9. Steinberg, Bernhard, Cleveland, Ohio.

5. That the following named eight Fellows be allowed to change their membership from one District Society to another without change of legal residence, under the provisions of Chapter III, Section 3, of the By-Laws:

One from Essex South to Suffolk

1. Goodale, Robert Lincoln, Ipswich.

Five from Middlesex South to Suffolk

1. Garfin, Samuel William, Allston.
2. Goldman, Joseph, Allston.
3. Knowlton, Charles Davison, Cambridge.
4. Sullivan, Russell Francis, Malden.
5. Wheeler, Roy Russell, Cambridge.

One from Norfolk to Suffolk

1. Rock, John, West Roxbury.

One from Norfolk South to Suffolk

1. Konrad, Frank Charles William, Weymouth.

DAVID N. BLAKELY, *Chairman.*

The Secretary read the reports of the committees appointed to consider the petitions of C. A. Davenport, F. A. Robinson and J. P. Graham, to be restored to the privileges of fellowship and it was voted to restore them under the conditions specified in each report. On nomination by the Chair the following committees were appointed to consider the petitions of these six Fellows:

H. E. Diehl
W. G. Curtis
F. E. Jones
J. H. Ash

C. N. Brady
F. M. Sherman
I. J. Fisher
W. A. Putnam

H. G. MacKerrow
L. C. Miller
R. P. Watkins
W. P. Lynch

T. J. Cahill
J. P. Nelligan
W. C. Feeley
F. J. Lynch

H. L. Roberts
R. S. Benner
R. B. Ober
F. B. Sweet

P. E. Joslin
C. E. Ayers
G. F. Curley
C. C. Weymouth

Dr. G. Forrest Burnham, Chairman, reported a new list of medical schools and colleges, approved by the Council, diplomas from which are to be recognized by the Censors in admitting new Fellows. The Committee on Medical Education and Medical Diplomas had made but three additions to the former list. On his motion the report was accepted and ordered printed.

Dr. M. Victor Safford, Chairman of the Committee on Public Health said that his committee was still trying to help the Fellows of the Society to determine the therapeutic usefulness of radiations from sources of light or heat; a recent effort in that direction was a paper just submitted to the *Journal*, a report from Professor W. T Bovie on the sort of radiations from the ultra-violet lamp (see *Boston Medical and Surgical Journal*, February 9, 1928, pages 1509-1516). Soon the committee would publish in the *Journal* a report from the United States Bureau of Standards covering the matter of the actual degree of transmissibility of various kinds of glass to ultra violet rays, whether from the sun or lamps. The question whether a person should be licensed by some state authority before being eligible as a health officer or sanitary inspector in towns which are over a certain size, had been brought before his committee, but as yet no recommendation had been made. The committee had been asked as to the practicability of voluntary combinations of small towns for the employment of full time health officers in order to secure better health service for the population of rural communities. The committee had written the Massachusetts Commissioner of Public Health asking him to demonstrate the practicability or impracticability of the idea through one of his District Health Officers in the Western part of the State.

Dr. Safford read a portion of a letter written by him to President Birnie as to the Massachusetts Central Health Council (See Appendix No. 2) and introduced the following motion.

Request having been made by the Massachusetts Central Health Council, through its Secretary, Dr. Henry B. Elkind, that its new Constitution, submitted under date of November 16, 1927, be ratified by the Massachusetts Medical Society, I move that the Council of the Society approve this Constitution as submitted with the stipulation that such approval shall not be construed to change or modify the application of any by-law of the Massachusetts Medical Society.

The motion being duly seconded was passed. Dr. Safford spoke of the danger of delay in the making of diagnoses of early tuberculosis and of the campaign about to be inaugurated by the National Tuberculosis Association to educate the public to a realization of this danger. He made this motion, and it was passed.

Whereas, Early and appropriate therapeutic measures are highly important in cases of active tuberculous infections and as it is to be assumed that efforts on the part of the National Tuberculosis Association to educate the public will be conducted with due regard for accuracy of information and propriety of methods for securing publicity, the Council of the Massachusetts Medical Society approves the "early

diagnosis campaign" of the Association as a movement worthy of the support of the Massachusetts Medical Society.

The report of the Committee on Public Health to the Council was then accepted as a whole, by vote. Dr. A. G. Rice, Chairman of the Committee on Insurance, read a report of progress. It was accepted and its recommendations adopted. (See Appendix No. 3.) Dr. J. W. Bartol, Chairman, presented the report of the Committee to Revise the By-Laws. (See Appendix No 4.) Every Councilor had been sent a copy of the revised By-Laws six days in advance. He explained at length the changes which had been made, after conference and correspondence with the officers and the chairmen of the standing committees; there had been many changes of wording; the standing committees were eight in number, each of five members, thus making for uniformity; the oldest committee, that on publications, had been shorn of the added title "scientific papers", as no longer necessary. This committee in future to have charge of the official organ as well as of other publications. To supply an omission in the requirements for fellowship he offered an amendment to Section 1, Chapter I, Seventh line, after the word "Council", insert: "or that they have, in each instance, received the approval of the Committee on Medical Education and Medical Diplomas". This was put to a vote and adopted, thus bringing the section into conformity with the rewritten Section 5, Chapter VII. Dr. Mongan moved that Section 4, Chapter VI (Duties of the Treasurer) be amended in the third paragraph, second line, after the word "report" by deleting the rest of the sentence and adding: "of the assets and liabilities on December 31, of the previous year, and also the financial transactions of the Society during that year." The motion was voted on and passed, thereby defining more accurately the duties of the Treasurer. As regards the new section added to Chapter VII as Section 8, exactly as approved by the Council at its last annual meeting, namely the duties of the new standing committee on malpractice defence, there was much discussion, participated in by Dr. Balch, chairman of that committee, Dr. Woodward, Dr. Lambert, Dr. Cheever, Dr. Merrill, Dr. Bowers and others. Finally this section was referred back to the Committee to Revise the By-Laws for rewording, and report to the meeting of the Council on June 5, 1928, through the amended draft of the By-Laws, which will be sent to every Fellow with the official program on May 6, one month before the Annual Meeting of the Society.

Dr. R. B. Greenough, Chairman, read a report of his Committee on Cancer. (See Appendix No. 5.) It was accepted and its recommendations adopted, it being understood that the request for an appropriation would be submitted, under the provisions of Chapter IV, Section 8, to the Committee on Membership and Finance.

The reports of the Treasurer, Auditing Committee and the Certified Public Accountant's Reconciliation between the Profit and Loss and Budget were submitted by Dr. D. N. Blakely, in the absence of the Treasurer. They were accepted. (See Appendix No. 6.) Dr. Blakely read the report of the Committee on Membership and Finance, on Finance, the Budget for 1928. (See Appendix No. 7.) He explained why the added salary of the assistant to the President would not require an increase of the Society dues at present, for the Society has not been expending the amounts appropriated, in recent years. Dr. T. J. O'Brien took the floor and spoke of the need of greater facilities and enlarged quarters at the Society's rooms; of the desirability of having there an assistant to the President so that the office of president may be held by a man living at a distance; the Society was fortunate to have such an able and patriotic man to fill the position of assistant. On motion, duly seconded, the Budget was accepted.

The Chair nominated and the Council appointed these delegates to the annual Congress on Medical Education, Licensure and Hospitals at Chicago, February 6, 7, 8, 1928: J. Forrest Burnham, T. J. O'Brien; also these delegates to the House of Delegates, American Medical Association for a term of two years from June 1, 1928: H. G. Stetson, *Alternate*, L. A. Jones; C. E. Mongan, *Alternate*, Gilman Osgood; J. F. Burnham, *Alternate*, W. C. Leary, also the following as delegates to the annual meetings of the New England State Medical Societies:

MAINE: A. E. Parkhurst, Beverly; H. P. Stevens, Cambridge.
NEW HAMPSHIRE: F. W. Snow, Newburyport; R. E. Stone, Beverly.
VERMONT: B. W. Paddock, Pittsfield; J. B. Thomes, Pittsfield.
RHODE ISLAND: A. R. Crandell, Taunton; E. D. Gardner, New Bedford.
CONNECTICUT: R. B. Ober, Springfield; G. D. Henderson, Holyoke.

To fill a vacancy in the new Committee on Malpractice Defence caused by the resignation of F. H. Baker, R. P. Watkins, of Worcester, was appointed. C. F. K. Bean was appointed supervising Censor of Middlesex South to fill a vacancy and R. J. Ward, a Censor of Worcester. Dr. Bowers made a motion that the privileges of the floor be given to F. B. Lund to explain the advisability of forming a branch of the American Medical Association's Woman's Auxiliary, in Massachusetts and it was so voted. Dr. Lund called attention to the branch that has been formed in the State of New Hampshire, the activities of the Woman's Auxiliary had been sketched in the *Bulletins* of the national society during the past year, the aims are to assist in entertaining at annual meetings and publicity; he thought that there should be a branch in this state. On motion by

Dr. Bowers it was *Voted,* That the President be and he is hereby authorized to select a committee from among the delegates of Massachusetts to the House of Delegates, American Medical Association, to consider the advisability of forming a branch of the Woman's Auxiliary in this state and to report their conclusions to the Council. In accordance with this vote the President appointed: C. E. Mongan, Chairman, F. B. Lund and R. I. Lee. Dr. E. A. Knowlton made the following motion, which was duly seconded, approved by the Chair and passed: *Moved,* That the Chair appoint a committee of five to consider ways and means of acquiring a permanent home for the Massachusetts Medical Society with power to act under the following conditions: 1) To secure an option upon property, provided the Committee on Membership and Finance gives its unanimous consent to the specific contract. 2) To facilitate its functions by appointing sub-committees from the District Societies. 3) To solicit funds to acquire a permanent home for the Massachusetts Medical Society, if it deems advisable. It is hereby understood that the above named committee cannot obligate the Massachusetts Medical Society in any way unless it has acquired sufficient funds from solicitation to carry out its program. The following were duly appointed: J. M. Birnie, T. J. O'Brien, S. B. Woodward, Henry Colt, C. G. Mixter.

In accordance with the vote of the Council, October 5, 1927, and the passing of the Budget at this meeting, establishing a salary, the Chair appointed as Assistant to the President, Dr. James S. Stone, of Boston.

Adjourned at 2:10 p. m.

WALTER L. BURRAGE, *Secretary.*

APPENDIX TO THE PROCEEDINGS OF THE COUNCIL

NO. 1

REPORT OF THE COMMITTEE OF ARRANGEMENTS

I have been asked to give a report for the Committee of Arrangements of our activities up to the present time in arranging for the Annual Meeting of the Society, which is to take place in Worcester on Tuesday and Wednesday, June 5th and 6th. We have reserved the necessary space in the Hotel Bancroft and the adjoining Chamber of Commerce Building. There is ample room to accommodate adequately the Section meetings and other usual functions. We have decided on a two-day meeting, because we considered that the attendance at clinics and other entertaining functions that could be arranged would not be sufficient to justify giving an extra day to them. Fortunately, the six Sections divide themselves up as far as attendance is concerned, into three large and three small meetings. Therefore, the program, as it now stands, is to hold one large and one small Section meeting simultaneously on Tuesday morning at 9:00, again on Tuesday afternoon at 2:30 and on Wednesday morning at 9:00. The larger meetings will be held in the Ball Room of the Chamber of Commerce Building, from which there is direct communication with the hotel itself. The smaller meetings will be held in the large Private Dining Room on the mezzanine floor of the hotel. This arrangement allows us to reserve the Ball Room of the hotel for the Tuesday noon Luncheon and the Annual Dinner on Wednesday, thereby avoiding the delay necessary in setting up tables and china before luncheon or dinner could be served if meetings were held in that room.

The members will enter the Chamber of Commerce Building to register. There will be an Information Desk there.

The meeting of the Council will take place on Tuesday at noon in the large Private Dining Room on the mezzanine floor. A buffet luncheon will be served in the hotel Ball Room at 2:00 o'clock, which will include the Cotting Lunch, as was the case last year in Boston. No special arrangements have been made for serving dinner Tuesday evening, but the main Dining Room and Cafeteria of the hotel should be able adequately to take care of the members' needs. The Shattuck Lecture will be given at 8:00 o'clock Tuesday evening in the Ball Room of the hotel, followed immediately at 9:00 o'clock by some moving pictures, during which we will be seated at small tables where light refreshments may be served and we shall have the services of the hotel orchestra. If the members so desire, we can make arrangements to have some informal dancing following the moving pictures.

On Wednesday the Annual Meeting of the Society will take place at 12:30 in the Ball Room of the Chamber of Commerce Building. The meeting will be followed by the Annual Discourse at 1:00 o'clock in the same room. The Annual Dinner will start immediately after this in the Ball Room of the hotel.

The Local Committee in Worcester has been kind enough to make arrangements so that any member may play golf at either of the Country Clubs by applying at the Information Desk. It is of interest that the links at the Worcester Country Club are among the finest in the country.

Parking Laws in Worcester are very strict and well enforced. Consequently, detailed directions in leaflet form will be given members when they register.

The Commercial Exhibits will be displayed in a series of Private Dining Rooms on the mezzanine floor. This location was chosen because it is on the way from the hotel lobby to the smaller Section meetings—a point which the exhibitors insist upon. There is room for about fifteen exhibits. The Meeting appears to be very compact, and although we should like to have an increased number of exhibits, both commercial and scientific, yet we could not very well give up either of the large rooms to them, and the proposed arrangement seems to be the best under the circumstances. The moving pictures, music and dancing, and music at the time of the annual dinner add some touches of lightness to the program.

Dr. A. W. Marsh's local committee has shown extraordinary zeal and efficiency. In fact its work is the chief reason for the present rather advanced progress of our plans. I am sure that we can count not only on the genial hospitality but also on the forethought and efficiency of our Worcester hosts. I hope that the arrangements, as far as they have gone, meet with your approval and that we shall have a successful meeting in June.

W. T. SHERMAN THORNDIKE, *Chairman.*

NO. 2

COMMITTEE ON PUBLIC HEALTH

The Massachusetts Central Health Council was brought into being about nine years ago by certain Fellows of the Massachusetts Medical Society in

an effort to provide a definite means of securing coöperation among statewide public health agencies in the State of Massachusetts, in the interest of Public Health. The following organizations have joined with the Massachusetts Medical Society in designating two representatives each to compose the membership of the Central Health Council as it has existed up to the present.

American Society for the Control of Cancer.
Dental Hygiene Council of Massachusetts.
Massachusetts Association of Boards of Health.
Massachusetts Association of Directors of Public Health Nursing.
Massachusetts Department of Public Health.
Massachusetts Society for Mental Hygiene.
Massachusetts State Nurses' Association.
Massachusetts Tuberculosis League.
Massachusetts Veterinary Association.
New England Heart Association.

By vote of the Massachusetts Central Health Council, its Secretary, Dr. Henry B. Elkind, requests the Massachusetts Medical Society, as an organization represented by the Council, to "ratify" the proposed new Constitution and By-laws of the Council.

So far as the Committee on Public Health of the Society is able to determine the proposed new Constitution and By-laws of the Council impose no obligations on the Massachusetts Medical Society, except to appoint two Fellows to a newly created Administrative Board of the Council, and in addition two Fellows to each of the six newly created District Councils to give local effect to the purposes of the organization throughout the State, and to contribute $10.00 annually toward its expenses.

The designation of a Fellow of the Society as its representative on the Administrative Board or local Council does not impose upon the Society any responsibility for any action which its representative or the Central Health Council as a whole may take in any matter, and in any event the Society may regularly terminate relations with the Central Health Council on sixty days' notice. In the opinion of the Public Health Committee the general purpose of the Central Health Council is laudable and there is a field of practical usefulness for such an organization.

NO. 3

Report of the Committee on Insurance

Your Committee on Insurance was from the start confronted with the necessity for speed, an urge that would tend to bring about a hurried decision which might easily, therefore, be erroneous. It was quickly realized that answers to pertinent questions could not be obtained in the time allotted. Inasmuch, however, as some report was imperative, your Committee agreed on a temporary decision that would suffice for a year during which time it hoped that enough information might be forthcoming to warrant a permanent one. A report of that character was, therefore, according to instructions, published in the *Boston Medical and Surgical Journal*, and will not now be read unless the Council so desires.

Since the publication of that report your Committee feels that the question of why so few Insurance Companies issue physicians' liability insurance in Massachusetts has been answered. Insurance Companies, with the exception of three writing such policies, claim that they cannot make the business pay. The next question to which your Committee desired an answer was why more physicians in Massachusetts did not carry liability insurance. From personal conversations and written inquiries your Committee feels warranted in revising its previous estimate, for it has happily learned that a very considerable proportion of doctors in this State do insure themselves against malpractice suits. With very few exceptions, those who have failed so to protect themselves have fallen into that error from thoughtlessness or apathy. In other words physicians in respect to insurance are no different from any other class of men, they too must be actively solicited. This aspect of the matter was pointed out to Mr. G. H. Crosbie who promptly acted on the suggestion and now employs solicitors whose experience is eagerly awaited. The answer to the third question is not one but many. From personal interviews, from correspondence, and from the brief experience of Mr. Crosbie and his solicitors, your Committee has obtained many answers to the question why only a minority of physicians patronize the company recommended. 1. Insurance has for years been carried with another company which is equally sound, no more expensive, and which has ever given satisfaction, reasons which urge a continuance, rather than warrant a change, of patronage. No comment is needed. 2. The rates are lower in other companies. This is not true in the aggregate, but only of certain classes: general practitioners, for example, are rated lower by one company whose rate for surgeons on the other hand is correspondingly higher. It is only natural that men choose the company whose rate for their class is lowest. 3. A local agent is preferred to a distant one. There is a natural feeling that keener interest will be shown by an agent who is easily and quickly accessible, who is a personal friend, and in whom explicit trust is therefore placed. 4. The present policy with another company has not expired. This of course is merely begging the question. 5. There seems to be a rather widely shared feeling that concentration in one company will benefit neither the Society nor its individual members, but solely the favored company which may come to believe it enjoys a monopoly, and may therefore juggle rates at will.

Other reasons, less helpful and for the most part individualistic, were offered to the effect that the complainant simply disliked the company recommended or its agent; disliked the way in which suits had been defended; disliked the local lawyers who handle the company's business; and so on, all personal objections most difficult properly to appraise.

Your Committee feels that the valid reasons given for not patronizing the particular company recommended would apply equally well against any favored company. The United States Fidelity and Guaranty Company is in its seventh year of activity with the recommendation of the Massachusetts Medical Society behind it, yet seems able to enroll less than half the present policy holders. Apparently physicians in Massachusetts can be more easily led to insurance than they can be made to partake of a special offering, however strongly recommended. Whether they can ever be driven to any one company is a question that cannot be answered until the complete experience derived from active solicitation now in progress is analyzed. If such concentration can be obtained it remains to be seen if to the company and the Society alike the game is worth the candle, financially and otherwise.

Your Committee, therefore, respectfully asks for still more time in which to draft its final report.

Allen G. Rice.
Charles A. Sparrow.

NO. 4

Report of the Committee to Revise the By-Laws

The Committee appointed by the Council, October 5, 1927, to revise the By-Laws of the Society herewith presents the result of their labors to the Council. No radical changes have been made. The following may be considered as a summary of the

changes recommended, after conferences with the officers and chairmen of the standing committees:

CHAPTER I, Section 3. This section has been omitted as no longer necessary. In its place a definition of resident and non-resident fellows has been inserted. Section 4 of the same chapter has been rewritten in order to create the membership denominated "Associate Fellow."

CHAPTER III, Section 5. A definite time for estimating the total membership of a District Society, that is, January 1, when the annual directory is issued, has been inserted, in order to obtain uniformity throughout the Society.

CHAPTER IV, Section 1. The secretaries of the District Societies have been added to the other members of the Council, who become automatically members without election by the Districts, thus giving the Districts more effective representation in the governing body of the Society.

CHAPTER VI, Section 5 has been omitted as the Society no longer has a librarian.

CHAPTER VII, Section 2. The Committees of Nine and of Publications and Scientific Papers have been combined into one Committee on Publications, having charge of the official organ, the directory, and the Shattuck Lectureship, also the rules for papers and discussions.

Section 5. The duties of this committee on Medical Education and Medical Diplomas have been rewritten, authorizing the committee to pass on the vote of the Council, June 9, 1914, as to applicants for fellowship who are not graduates of medical colleges on the list approved by the Council.

Section 7. The duties of the Committee on Public Health have been rewritten in accordance with the recommendations of the chairman of that committee.

CHAPTER VIII, Section 3. This section, describing the duties of Fellows who may be brought into contact with charges of a criminal nature, has been omitted as unnecessary in the by-laws of a medical society and coming under the General Laws of the Commonwealth.

All of the amendments to the By-Laws that have been passed by the Society since the last revision in 1920, and the amendments passed by the Council last June, have been introduced in their appropriate places in this revision.

JOHN W. BARTOL, *Chairman*,
HALBERT G. STETSON,
HARVEY W. VAN ALLEN,
HENRY JACKSON, JR.,
WALTER L. BURRAGE, *Secretary*.

January 25, 1928.

NO. 5

REPORT OF THE COMMITTEE ON CANCER

Your committee has met to discuss the activities which properly come within its province. The members of this committee were consulted in an advisory capacity in the formation of the cancer program of the Massachusetts State Department of Public Health, and much attention was given to the carrying out of this program during the summer and fall of 1927. It seems appropriate, however, that cancer propaganda and education directed toward the members of the medical profession should emanate chiefly from this committee of the Massachusetts Medical Society. A campaign of such a nature addressed both to the public and the medical profession has been planned for the last week of April, 1928. In this campaign the Massachusetts State Department of Public Health, the Massachusetts branch of the American Society for the Control of Cancer and the Cancer Committee of the Massachusetts Medical Society propose to coöperate with the understanding that the Massachusetts Medical Society committee devote its efforts chiefly to work among the medical profession. For this purpose we would respectfully make application for an appropriation of $200 to be devoted to the general expenses of the committee, but chiefly for the purpose of offering to refund travelling expenses to eminent physicians and surgeons outside the State, in order that we may be able to provide competent speakers for the various district society meetings and those held in Boston at that time. We would also apply for permission to add to the present five members of this committee, a sixth member who may serve as an executive secretary.

ROBERT B. GREENOUGH, *Chairman*.
FRANKLIN G. BALCH,
GEORGE H. BIGELOW,
KENDALL EMERSON,
P. E. TRUESDALE.

NO. 6

AUDITING COMMITTEE'S REPORT

Your committee has examined the securities of the Massachusetts Medical Society, and finds them to be as scheduled in the accountant's report.

PAUL R. WITHINGTON,
GERALD BLAKE,
Auditing Committee.

January 31, 1928.

TREASURER'S REPORT FOR THE YEAR ENDED DECEMBER 31, 1927

ASSETS AND LIABILITIES OF THE MASSACHUSETTS MEDICAL SOCIETY DECEMBER 31, 1927

SCHEDULE A

ASSETS

Cash:			
New England Trust Co.		$7,356.25	
Old Colony Trust Co.		2,459.66	
			$9,815.91
Endowment Funds:			
Shattuck Fund:			
Annuity Policy Mass. Hospital Life Ins. Co.		$9,166.87	
Phillips Fund:			
Massachusetts 3½'s Gold Bonds		10,000.00	
Cotting Fund:			
Deposit in Institution for Savings in Roxbury and its Vicinity	$1,000.00		
Deposit in Provident Institution for Savings in the Town of Boston	1,000.00		
Deposit in Suffolk Savings Bank for Seamen and Others in Boston	1,000.00		
		3,000.00	

General Fund:			
Deposit in Franklin Savings Bank in the City of Boston		1,074.48	
Par Value			
$5,200.00	Liberty Bonds 4th Issue 4¼%	5,043.23	
5,000.00	Massachusetts 3½'s Bonds 1938	5,000.00	
1,000.00	U. S. Steel Corp. 5's 1963	1,009.00	
2,000.00	U. S. Rubber Bonds 5's 1947	1,735.50	
2,000.00	American Sugar Refining Co. 6's 1937	1,972.50	
2,000.00	Great Northern Ry. Co. 5½'s 1952	1,932.50	
2,000.00	Adirondack Power and Light Co. 6's 1950	1,970.00	
4,000.00	Public Service Co. No. Ill. 5's 1956	3,640.00	
3,000.00	Mallory S. S. Co. 5's 1932	2,760.00	
3,000.00	Dayton Power and Light Co. 5's 1932	2,797.50	
2,000.00	Conveyances Title Insurance Co. 5½% Parti-Mortgage, due Dec. 1, 1929	2,000.00	
3,000.00	Commonwealth of Australia 5's 1955	2,985.00	
3,000.00	Toledo Edison Co. 5's 1947	2,805.00	
3,000.00	U. S. Cold Storage Bonds 6's 1945	3,000.00	
3,000.00	Wilson & Co. 1st 6's 1941	3,006.00	
3,000.00	Cedar Rapids Mfg. Power Co. 5's 1953	2,805.00	
3,000.00	Guaranty Title & Trust Co. 5½'s 1936	3,000.00	
1,000.00	American Tel. & Tel. Co. 5½'s 1943	985.00	
3,000.00	Appalachian Electric Co. 5's 1956	2,910.00	
3,000.00	International Paper 6's 1955	3,076.00	
			77,673.58
Boston Medical and Surgical Journal			1.00
Total			$87,490.49

LIABILITIES

Endowment Funds:			
Shattuck Fund (G. C. Shattuck 1854, Balance 1866)		$9,166.87	
Phillips Fund (Jonathan Phillips 1860)		10,000.00	
Cotting Fund (B. E. Cotting $1,000.00—1876, 1881, 1887)		3,000.00	
			$22,166.87
General Fund Account:			
Balance, January 1, 1927 (Adjusted) *Exhibit 1*		$60,666.83	
Unexpended Balance for the year ended December 31, 1927—*Schedule B*		4,656.79	
			65,323.62
Total			$87,490.49

ADJUSTED GENERAL FUND ACCOUNT

JANUARY 1, 1927

SCHEDULE A—EXHIBIT 1

Balance, January 1, 1927		$60,561.83
Add,—Profit on Georgia Railway and Power Co. Bonds called April 1, 1927		105.00
Balance, January 1, 1927 (Adjusted)—*Schedule A*		$60,666.83

STATEMENT

SHOWING THE CURRENT ACCOUNT OF THE MASSACHUSETTS MEDICAL SOCIETY FOR THE YEAR ENDED DECEMBER 31, 1927

SCHEDULE B

CREDIT

Assessments Received by District Treasurers:		
Barnstable		$272.00
Berkshire		832.00
Bristol North		490.00
Bristol South		1,592.00
Essex North		1,120.00
Essex South		1,391.00
Franklin		264.00
Hampden		2,044.00
Hampshire		456.00
Middlesex East		710.00
Middlesex North		864.00
Middlesex South		4,448.00
Norfolk		4,509.00

Norfolk South		680.00	
Plymouth		777.00	
Suffolk		5,672.00	
Worcester		2,552.00	
Worcester North		661.00	
			$29,334.00
Assessments Received by Treasurer			3,217.94
Total			$32,551.94
Income from Shattuck Fund		$458.34	
Income from Phillips Fund:			
Mass. 3½'s Bonds		350.00	
Income from Cotting Fund:			
Interest—Institution for Savings in Roxbury and its vicinity	$45.00		
Interest—Suffolk Savings Bank for Seamen and Others in Boston	45.00		
Interest—Provident Institution for Savings in the Town of Boston	45.00		
		135.00	
Income from Permanent Funds:			
Franklin Savings Bank	$48.34		
Liberty Bonds 4¼%	221.00		
Massachusetts Bonds 3½'s	175.00		
U. S. Rubber Co. Bonds	100.00		
U. S. Steel Co. Bonds	50.00		
American Sugar Refining Co. Bonds	120.00		
Commonwealth of Australia	150.00		
Great Northern Railway Co. Bonds	110.00		
Adirondack Light and Power Bonds	120.00		
Cedar Rapids Mfg. Co. Bonds	150.00		
Dayton Power and Light Co. Bonds	150.00		
Toledo Edison Co. Bonds	150.00		
Public Service Co. No. Ill. Bonds	200.00		
Georgia Railway and Power Co. Bonds	90.00		
American Tel. & Tel. Co. Bonds	55.00		
Appalachian Electric Co. Bonds	150.00		
Mallory S. S. Co. Bonds	150.00		
U. S. Cold Storage Bonds	180.00		
Guaranty Title and Trust Co. Bonds 5½'s	165.00		
Conveyancers Title Insurance Co. (Parti-Mortgage)	110.00		
International Paper Bonds	90.00		
Wilson Co. Bonds 6's	90.00		
	$2,824.34		
Less,—*Interest Advanced on Permanent Funds Purchased:*			
Conveyancers Title Insurance Co. (Parti-Mortgage Purchased)	$38.50		
International Paper Bonds	23.50		
Wilson & Co. 6's	6.50		
	68.50		
		2,755.84	
Income from Deposits in Banks:			
New England Trust Co.	$331.03		
Old Colony Trust Co.	61.22		
		392.25	
Miscellaneous Income		1.00	
			4,092.43
Total			$36,644.37

DEBIT

General Expenses:			
President's Expense		$354.72	
Secretary's Expense		595.71	
Treasurer's Expense		234.53	
District Treasurers' Expense		1,697.61	
Censors' Expenses		604.88	
Delegates' Expenses (A. M. A.)		431.74	
Committee Room Expenses:			
Telephone	$93.70		
Rent	489.96		
Janitor	56.50		
Salaries	500.00		
Light	8.97		

Supplies	10.85		
Miscellaneous Items	106.87		
	*1,266.85		
Salaries	3,000.00		
Rent	1,200.00		
Miscellaneous Expenses	.08		
		9,386.12	
Boston Medical and Surgical Journal		11,500.00	
Shattuck Lecture		200.00	
Committee Expenses:			
Arrangements	$3,507.07		
Publications and Scientific Papers	8.38		
Membership and Finance	2.00		
Medical Education and Medical Diplomas	90.53		
State and National Legislation	312.35		
Public Health	336.19		
Indemnity Insurance	125.89		
		4,382.41	
Annual Dividends to District Societies		4,000.00	
Defense of Malpractice Suits		2,268.25	
Cotting Lunches		250.80	
Total Expenses			31,987.58
Balance Transferred to General Fund Account			$4,656.79

*Detailed explanation of this item on file for inspection at Committee Room.

Received from all sources during the year 1927	$36,644.37
Expended as per vouchers	31,987.58
Balance	$4,656.79
Cash on hand Dec. 31, 1927	$9,815.19

ARTHUR K. STONE, *Treasurer.*

RECONCILIATION BETWEEN THE PROFIT AND LOSS AND BUDGET FOR THE YEAR ENDED DECEMBER 31, 1927

By Hartshorn and Walter, Certified Public Accountants

	Profit and Loss Account	Budget Estimate	Difference Under-Estimated	Difference Over-Estimated
REVENUE:				
Assessments	$32,551.94			
Interest from Investments	3,699.18			
Interest on Bank Deposits and Miscellaneous Income	393.25			
Total Society Revenue	$36,644.37	$37,000.00		$355.63
Decrease of Revenue to Budget Estimate		355.63		
Total as per Auditors' Report	$36,644.37	$36,644.37		
EXPENSES:				
Salaries of Officers:				
Secretary	$2,500.00	$2,500.00		
Treasurer	500.00	500.00		
Officers' Expenses:				
President	354.72	250.00	$104.72	
Secretary	595.71	750.00		$154.29
Treasurer	234.53	400.00		165.47
District Treasurers	1,697.61	1,500.00	197.61	
Censors	604.88	500.00	104.88	
Delegates (A. M. A.)	431.74	800.00		368.26
Rent	1,200.00	1,200.00		
Journal	11,500.00	15,000.00		3,500.00
Defense of Malpractice Suits	2,268.25	2,000.00	268.25	
Shattuck Lecture	200.00	200.00		
Cotting Lunches	250.80	500.00		249.20
Committee Room Expenses	1,266.85	2,000.00		733.15
Standing Committees:				
Arrangements	3,507.07	6,150.00		*2,642.93
Publications and Scientific Papers	8.38	200.00		191.62
Membership and Finance	2.00	25.00		23.00

Ethics and Discipline		25.00		25.00
Medical Education and Medical Diplomas	90.53	200.00		109.47
State and National Legislation	312.35	900.00		587.65
Public Health	336.19	600.00		263.81
Public Instruction		200.00		200.00
Indemnity Insurance	125.89		125.89	
Dividends to District Societies	4,000.00	4,000.00		
Miscellaneous Expense	.08		.08	
Total Expenses as per Auditors' Report	$31,987.58		$801.43	$9,213.85
Total Budget		$40,400.00		
Expenses Over-Estimated	8,412.42		8,412.42	
	$40,400.00	$40,400.00	$9,213.85	$9,213.85
Expenses Over-Estimated	$8,412.42			
Revenue Over-Estimated	355.63			
Net Amount of Expenses Over-Estimated	$8,056.79			
Deduct, — †Budget charge to General Fund Account	3,400.00			
Balance Transferred to General Fund Account	$4,656.79			

*Over-estimated amount almost wholly caused by a credit of $1329.80 received from exhibitors and $1342.50 received in cash at annual meeting.

†Amount by which Budget Estimated Expenses exceeded Budget Estimated Income.

NO. 7

REPORT OF COMMITTEE ON MEMBERSHIP AND FINANCE, ON FINANCE BUDGET FOR 1928

APPROPRIATIONS

Salaries:		
Secretary	$2,500	
Treasurer	500	
Assistant to President	5,000	
		$8,000
Expenses of Officers and Delegates:		
President and Vice-President	$500	
Secretary	750	
Treasurer	400	
District Treasurers	1,700	
Censors	600	
Delegates to House of Delegates, A. M. A.	800	
		4,750
Rent, Boston Medical Library		1,200
Boston Medical and Surgical Journal		15,000
Malpractice Defense		2,000
Shattuck Lecture		200
Cotting Lunches		500
Committee Room Rent and Expenses		2,500
Printing, Postage and other expenses of Committee to revise By-Laws		600
Delegates to New England Medical Council		100
		$34,850
Standing Committees:		
Of Arrangements for Annual Meeting	$3,000	
Publications and Scientific Papers	200	
Membership and Finance	25	
Ethics and Discipline	25	
Medical Education and Medical Diplomas (including expenses of Delegate to annual Congress at Chicago)	200	
State and National Legislation (including expenses of Delegate to annual Congress at Chicago)	500	
Public Health	600	
Public Instruction	200	
		4,750
Dividends to District Societies		4,000
Total		$43,600
Income as Estimated by Treasurer		37,000
To be taken from General Fund		$6,600

Feb. 1, 1928.

DAVID N. BLAKELY, *Chairman.*

ORIGINAL ARTICLES

THE THYMUS OBSESSION

BY JOHN LOVETT MORSE, M.D.

IT has recently become the fashion, not only for pediatrists but for physicians in general, to attribute all the disturbances of infancy and early childhood, which they cannot lay to rickets, to the thymus. The function of the thymus being for all practical purposes unknown, it is easy for them to assume that an increase or diminution in its hypothetical secretion may cause any and all symptoms. A Roentgenogram of the chest shows, of course, the shadow of the thymus. If this is larger than they think it ought to be, it proves, to them, that an enlarged thymus is the cause of the symptoms. If the shadow is no larger than they think it should be, they say that there is something wrong with the picture and still attribute the symptoms to the thymus. Whatever the size of the shadow, they are likely to advise treatment with the Roentgen ray. If the symptoms diminish or disappear at any time after treatment with the Roentgen ray, they are satisfied that the improvement was due to shrinkage of the thymus, *post hoc, propter hoc*, always being a satisfactory explanation to many minds. If there is no improvement in the symptoms, they are likely to recommend more treatment with the Roentgen ray or shift to ultraviolet ray treatment or cod liver oil, although occasionally some one admits that he is wrong and looks for some other cause for the symptoms.

Physicians in general apparently do not grasp the fact that there is a difference between the symptoms which an enlarged thymus may cause by pressure on the other structures in the anterior mediastinum, those which may be due to a continuous or intermittent increase or diminution in the hypothetical internal secretion of the thymus, and those which may result from status lymphaticus, of which enlargement of the thymus is only one manifestation. There also seems to be a general lack of knowledge as to the normal size and growth of the thymus and as to the size of the "normal" shadow of the thymus as shown by the Roentgen ray.

According to Hammar, Scammon, and Boyd the average weight of the thymus at birth is 13 gms. After a shrinkage of from 5 to 8 gms. during the first two weeks after birth, the weight increases to about 17 gms. at six weeks and 20 gms. at six months. It then gradually increases to 35 gms. at puberty and atrophies to 15 gms. at fifty years. The thymus also diminishes in weight in inanition and in any condition, whether acute or chronic, which causes loss of weight. It also diminishes in size in many acute diseases before there is loss of weight. It is evident, therefore, that the largest thymuses and, consequently, the largest thymic shadows are found in the healthiest and best nourished infants and children. Of interest in this connection and of much importance in relation to status lymphaticus is the fact that the lymphoid tissue of the body in general follows the same curve of growth.

The size of the thymic shadow, as shown in the Roentgenogram, varies according to the position of the child when the Roentgenogram is taken and the technic used. It is larger in inspiration than in expiration. Roentgenograms are untrustworthy, therefore, unless the patient is always in the same position, the technic is always the same and they are taken in full expiration. Roentgenograms, as they are ordinarily taken, show nothing, moreover, as to the thickness of the thymus. There is ample evidence to show that the thymus and, in consequence the thymic shadow, varies in size from day to day. This variation is probably due to the amount of blood which it contains. I have several times seen patients in whom the thymic shadow was much larger one day than it was the next. It is likely that if repeated Roentgenograms were taken during the day, it would be found that the size of the shadow varies from hour to hour.

It seems evident from the facts just given that it is impossible, even with perfect Roentgenographic technic, to lay down any arbitrary rules as to the "normal" size of the thymus, either in the new-born or in older infants and children. Roentgenographic technic being not infrequently far from perfect, it is evident of how little value many Roentgenograms of the thymus really are. It being impossible to determine from a Roentgenogram alone whether the thymus is of "normal" size for the given infant at the given time under the given conditions, it seems unreasonable to take Roentgenograms of the thymuses of all new-born babies, as is now being done at some hospitals and by some obstetricians. It seems still more unreasonable to allow a Roentgenologist, who knows nothing about the individual baby, to decide from the Roentgenogram whether the thymus is enlarged or not and whether it should be treated with the Roentgen ray to reduce its size. The only apparent object in diminishing its size would seem to be to protect the baby against sudden death from status lymphaticus. The possible fallacies in the commonly accepted views regarding status lymphaticus and the relations between it and enlargement of the thymus are discussed later. The unreliability of conclusions based on Roentgenograms of the thymuses of new-born babies is shown by the fact that a Boston baby, whose thymus was said by a Roentgenologist to be "normal" at birth, recently died suddenly, when

five weeks old, of what was called status lymphaticus.

The thymus, being situated in the upper part of the anterior mediastinum between the rigid spine behind and the rigid sternum in front may, if enlarged, cause pressure on the other important organs which are located in the superior entrance of the thorax. The arteries are so stiff that they resist pressure. The nerves are usually displaced and, therefore, avoid pressure. The veins may be compressed, but, like the nerves, are usually pushed aside. The trachea bears the brunt of the pressure. Pressure on the veins may cause cyanosis of the face and upper extremities. Pressure on the trachea may cause noisy respiration, dyspnea, retraction of the intercostal spaces and cyanosis. If the pressure is sufficient to cause noisy respiration, it will be noisy in both inspiration and expiration, because the pressure on the trachea is exerted during both inspiration and expiration. It is evident, therefore, that when inspiration only is noisy, the cause is not enlargement of the thymus. When noisy respiration is due to the pressure of an enlarged thymus it is increased by extension of the head, which narrows the upper opening of the thorax. When the thymus is enlarged enough to cause symptoms of pressure, it is almost always palpable in the suprasternal notch and there is definite dulness under the manubrium. Furthermore, the larynx is not depressed during inspiration, because it is kept up by the enlarged thymus. When the thymus is enlarged enough to cause symptoms and physical signs, the Roentgen ray will, of course, show a large thymic shadow. A large thymic shadow, in the absence of the characteristic symptoms and physical signs of enlargement of the thymus, does not prove, however, that other symptoms, often erroneously attributed to enlargement of the thymus, are due to it. In fact, it should never be necessary to take a Roentgenogram of the thymus to determine whether or not certain symptoms are due to the pressure of an enlarged thymus. Likewise it should not be necessary to take Roentgenograms to determine that certain symptoms are not due to an enlarged thymus. It should be plain that they are not due to it, even if the shadow is enlarged, without taking into consideration all the errors which are associated with Roentgenograms of the thymus.

I have seen cases in which the characteristic symptoms and signs of an enlarged thymus were present. Some of them were seen before the Roentgen ray was discovered and were relieved or cured by the removal of a part of the thymus. Some of them, seen later, were cured by treatment with the Roentgen ray. Such cases have, however, been very few. In the vast majority of the cases which I have seen, in which the symptoms have been attributed to enlargement of the thymus, they have manifestly been due to other easily discoverable causes, in spite of the fact that Roentgenograms were supposed to show an enlargement of the thymic shadow. The errors in diagnosis have almost always been due to the present tendency to attribute all disturbances of respiration and color in infants to enlargement of the thymus, the failure to study the symptoms carefully and ignorance of the unreliability of thymic shadows. In many instances the diagnosis of pressure from an enlarged thymus had already been proved to be wrong by the failure of Roentgen ray treatment to relieve the symptoms. It may be worth while to mention some of the more common mistakes, examples of all of which I have seen within the last few months.

Cyanosis in the new-born, not so many years ago, was always charged to congenital heart disease, usually to a patent foramen ovale! Now, especially in those hospitals in which it is the custom to take a Roentgenogram of the thymus of every new-born baby and trust to the Roentgenologist to decide whether it is enlarged or not, it is almost always attributed to an enlarged thymus. Anyway, whatever the cause, the poor baby has a few Roentgen ray treatments at the parents' expense. The causes of cyanosis in the new-born are the same now as they used to be, congenital heart disease, but not patent foramen ovale, atelectasis of the lungs, cerebral hemorrhage, congenital debility, chilling and adenoids, not to mention congenital anomalies, like diaphragmatic hernia and congenital hypertrophy of the heart, which are probably just as common as enlargement of the thymus with pressure. All these conditions are easily recognizable, if the trouble is taken to look for them. If it is, it will seldom be found necessary to take Roentgenograms of the thymus.

Intermittent attacks of slight cyanosis are not uncommon in infants and young children. These are nowadays often attributed to the thymus. There is no doubt, of course, that the thymus may vary rapidly in size, according to the amount of blood which it contains. It hardly seems reasonable to suppose, however, that an increase in the size would exert sufficient pressure on the trachea to cause cyanosis, without causing dyspnea and noisy respiration. It does not seem likely, moreover, that it would compress the veins, which slip aside so easily, enough to cause cyanosis without also exerting enough pressure on the trachea to produce the characteristic signs. There is, of course, no answer to the argument that the cyanosis is due to some change in the internal secretion of the thymus, because, if there is such a secretion, no one knows what it does and, consequently, no one knows what would happen, if there was a change in the amount of secretion. It seems much more reasonable to attribute these fleeting attacks of cyanosis to the unstable circulatory system of the infant than to the thymus. It is hard for me, at any rate, to believe that cyanosis about the mouth in a baby with the colic, in one that

is crying hard or that is easily chilled, has anything to do with either the size or internal secretion of the thymus, even if some one says that the thymic shadow is larger than he thinks it ought to be.

Many physicians apparently suspect enlargement of the thymus whenever an infant or young child has noisy respiration. A Roentgenogram is taken, which is interpreted as showing an enlargement of the thymus, a positive diagnosis of enlargement of the thymus is made and treatment with the Roentgen ray instituted, without any attention being paid to the characteristics of the respiration, the findings on physical examination or the possible errors in the taking or reading of the Roentgenograms. Under such circumstances the diagnosis is more likely to be wrong than right, and, in fact, it is. Treatment with the Roentgen ray does no good, of course, when the diagnosis is wrong. Furthermore, the diagnosis of enlargement of the thymus prevents them from performing operations which are indicated and which would relieve or remove the real cause of the trouble.

It does not seem as if the obstruction to respiration caused by adenoids could ever be mistaken for that due to pressure on the trachea from an enlarged thymus, the symptoms are so radically different. Nevertheless, in my experience, it is the mistake most often made. Physicians entirely overlook the snuffles, the "snorty nose", the open mouth, the difficulty in nursing, the predominance of symptoms in inspiration, and pin their faith on an untrustworthy Roentgenogram. Overlooking all these characteristic symptoms of adenoids and not looking for or not knowing the characteristic symptoms of pressure of the thymus, they do not, of course, examine the nasopharynx for adenoids. If they did, they could not miss them, as, in such cases, the nasopharynx is full. The following cases are examples.

A baby, three and one-half months old, had had trouble with breathing since birth. It had had four treatments with the Roentgen ray, the first when it was three weeks old. There had been a little improvement in the symptoms. The physician in charge wished the baby to have further treatments, but the Roentgenologist was unwilling, although the thymic shadow was but little smaller than in the beginning. The baby was constantly snuffling and had much difficulty in breathing with its mouth shut. It made a little noise in inspiration. None of the characteristic signs of enlargement of the thymus were present. A large amount of adenoids was felt with the finger. They were removed the next morning. That night the baby slept quietly. There has been no return of the symptoms after fifteen months.

A baby, seen when nine months old, had had snuffles and peculiar breathing at birth. A Roentgenogram at three months showed what was supposed to be an enlarged thymus. It was treated with radium and the ultraviolet ray! and had had half a dozen Roentgen rays taken, each of which, of course, amounted to a treatment. The symptoms had increased, nevertheless, up to a month before, since when they had remained unchanged. The baby was constantly snuffling and snorting, could not breathe with its mouth shut, had difficulty in taking its bottle and showed none of the classical symptoms of enlargement of the thymus. A large amount of adenoids was felt with the finger. Incidentally, a Roentgenogram taken to satisfy the mother showed a shadow which even the most enthusiastic advocate of hypertrophy of the thymus would admit to be normal.

The inspiratory crowing sound caused by a congenital narrowing or infolding of the epiglottis with consequent laxness of the aryepiglottidean folds or to a congenital elongation of these folds—congenital laryngeal stridor—is also not infrequently attributed to enlargement of the thymus. I have seen two babies within the last year in which this mistake was made and Roentgen ray treatment given, naturally without benefit. In congenital laryngeal stridor the crowing sound is always in inspiration only and is constant, varying only with the depth of respiration. There are no other symptoms and no physical signs, except the deformity of the larynx. If there is pressure on the trachea from an enlarged thymus, the abnormal sound is present in both inspiration and expiration, there is usually some cyanosis and the physical signs of enlargement of the thymus are present. There should be no trouble in recognizing the characteristic crow of congenital laryngeal stridor. When this is present, the size of the thymic shadow is of no importance whatever in diagnosis.

Attacks of laryngismus stridulus in spasmophilia are also occasionally attributed to enlargement of the thymus with pressure on the trachea. To make this mistake it must be assumed that the thymus enlarges tremendously and almost instantaneously, and as quickly diminishes in size. If it did not, the babies would always die in the first attack. Such an assumption is hardly reasonable. The symptoms of laryngismus stridulus are pathognomonic. The baby takes several short inspirations in rapid succession, each accompanied by a crowing sound. It then stops breathing with the chest in full inspiration. It quickly becomes cyanotic. After it becomes sufficiently asphyxiated, the spasm relaxes and it begins to breathe again. It is hard to see how a sudden enlargement of the thymus could produce a symptom complex like this. There are, moreover, always other signs of spasmophilia present: tetany, facial phenomenon, peroneal reflex and changed electrical reactions. It is not necessary to find a diminution in the calcium of the blood to make the diagnosis. I recently saw a baby sixteen months old, who had just returned from the South, having typical attacks of laryngismus stridulus. The physician there had recognized that he had tetany and yet, on the strength of what he thought was an increase in the thymic shadow, had given two Roentgen ray treatments, of course without benefit. A few treatments with the ultraviolet rays stopped the attacks.

Another condition for which enlargement of

the thymus is often considered responsible is breath holding, that is, a condition in which an infant or child stops breathing as the result of crying or fright and begins again after it gets sufficiently asphyxiated to relax the spasm. If breath holding is caused by an enlarged thymus, it is necessary to assume, as in laryngismus stridulus, that it swells up and goes down again instantaneously, which does not seem probable. Incidentally, a Roentgenogram of the thymus between attacks would show nothing as to its size in an attack. I saw an example of this mistake a few weeks ago.

A boy of twenty-three months began to have attacks in which he held his breath and became cyanotic at fifteen months. A Roentgenogram of the thymus at that time showed what was interpreted to be an enlargement of the thymic shadow. He was, therefore, given two Roentgen ray treatments, after which the attacks were, for a time, somewhat less severe. They then became more frequent and more severe. Another Roentgenogram failed to show any enlargement of the thymic shadow, which did not seem consistent to either the doctor or the parents. The Roentgenologist, however, wished to give him some more treatments. It was decided, nevertheless, to slap him on the back, dash cold water in his face or run him up and down the room instead.

Other diseases, whose symptoms I have known to be supposed to be caused by an enlarged thymus, are retropharyngeal abscess, tracheobronchial adenitis, bronchitis and asthma. All of these may cause noisy inspiration and expiration. In bronchitis, however, the noise is most marked in inspiration and in asthma in expiration. In tracheobronchial adenitis the noise is usually louder in expiration than in inspiration, because the thorax is smaller and the pressure greater in expiration. There are always other physical as well as Roentgenological signs in tracheobronchial adenitis, and a retropharyngeal abscess can always be felt with the finger. A new growth in the larynx may also cause noisy inspiration and expiration. There is always trouble with the voice when there is a new growth, while there is none when the difficulty in breathing is due to the pressure of an enlarged thymus. It hardly seems necessary to take up the differential diagnosis between dyspnea, cough and noisy breathing due to bronchitis or asthma and an enlarged thymus. They should never be confused. Nevertheless, when physicians have the thymus obsession, they overlook the most obvious signs and symptoms and can see nothing but the shadow of the thymus gland.

The thymus is not infrequently supposed to be responsible for convulsions, attacks of faintness, various manifestations of vasomotor instability and even colic. The demonstration of what is interpreted to be enlargement of the thymus by the Roentgen ray is accepted as conclusive proof that these symptoms are thymic in origin. It is hardly necessary to go over the arguments again to prove that it is not possible to determine from a Roentgenogram whether the thymus is larger than normal or not. Even if it could be shown that the thymus was larger than normal, it would not prove that there was any increase in its secretion. The thyroid is often enlarged in cretinism, for example, but its secretion is diminished. In the conditions now under consideration, the symptoms cannot be due to compression of any of the other structures in the anterior mediastinum by an enlarged thymus. If they are connected in any way with the thymus, they must be due to a change in its secretion, presumably to an increase. It is idle to argue whether an increase in the secretion of the thymus does or can cause such symptoms or not, because, as it is not known what the hypothetical secretion of the thymus does normally, it is impossible to know what will happen, if it is either increased or diminished. Theoretically, it seems as if many of the symptoms which are attributed to an excessive secretion of the thymus can be better explained by a diminution in the secretion of the adrenals. Improvement or disappearance of the symptoms after treatment of the thymus with the Roentgen ray with shrinkage of the shadow does not prove that the improvement was due to a diminution of the secretion of the thymus, because the size of the thymic shadow varies continuously, the symptoms cease in many instances without any Roentgen ray treatment and without any change in the size of the thymus, and the improvement may just as well be due to the disappearance of the real and undiscovered cause. Finding what is supposed to be an enlarged thymus post mortem in such cases does not prove that an increased thymic secretion was the cause of the symptoms, because there is no way of knowing whether the thymus is really enlarged, if it is, whether its secretion was increased, or, if it was, whether it would cause such symptoms. On the other hand, when improvement does occur after apparent shrinkage of the thymus by treatment with the Roentgen ray or a large thymus is found post mortem without other pathologic changes, it is impossible to prove that there was no connection between the symptoms and the thymus. It is useless to attempt to argue, however, when there are no premises on which to base the arguments. It is safe to say, nevertheless, that it is wise to look for other causes for the symptoms, even if the Roentgen ray shows what is thought to be a large thymus, before starting treatment with the Roentgen ray. It is certainly not reasonable to give thirty treatments with the Roentgen ray to an idiotic baby with spastic paralysis, because it had attacks of cyanosis, difficult breathing and mild convulsions, as was done in a case which I saw this summer.

Infants, children and adults sometimes die suddenly without any apparent cause or from some cause entirely insufficient to account for death, as at the beginning of anesthetization, from some sudden shock, the introduction of a

needle or in the course of some mild disease. In such cases enlargement of the thymus, spleen, lymph nodes, tonsils and Peyer's patches, hyperplasia of the bone marrow and hypoplasia of the heart and aorta are not infrequently found. The pathologic combination described above is spoken of as the status lymphaticus. When this condition is found in instances in which death has occurred suddenly without apparently sufficient cause, the death is said to have been due to the status lymphaticus. There is, however, no proof that death was due to it. It is purely an assumption, based on the absence of any other obvious cause. There are plenty of sudden deaths in which no evidences of status lymphaticus are found and plenty of deaths from other causes in which the pathologic changes of status lymphaticus are present. In this connection it may be pertinent to mention the little girl in Minnesota whose sudden death was attributed to status lymphaticus, but who later was found to have been electrocuted by stepping on an electrically charged stair, and another whose sudden death in a convulsion, at first attributed to status lymphaticus, was found to have been due to strychnia poisoning.

It has been quite generally assumed that the enlargement of the thymus is the most important pathologic change in status lymphaticus, and that the hyperplasia of the thymus is in some unknown way the cause of the other pathologic changes and of the sudden death. No one believes now, I think, that death in these cases is due to the mechanical pressure of the thymus. If it is due to the thymus, it must, therefore, be connected in some way with the hypothetical secretion of the thymus. It is hardly necessary to mention again that no one knows what the function of the thymus is after birth, whether it has any secretion or not, what the action of this secretion, if there is any, is normally, or what the symptoms of hypersecretion would be. Theoretically, an acute insufficiency of the secretion of the adrenals would seem to explain these sudden deaths, although there is, of course, no apparent reason why such an acute insufficiency should occur and certainly no reason for connecting it with the pathologic changes found in status lymphaticus. It is safe to say that there is no evidence to show that the enlarged thymus in status lymphaticus has anything to do with the causation of the other pathologic changes found in this condition. It is just as probable that the enlargement of the thymus is due to the same cause or causes as the other pathologic changes, if they are pathologic, or that the general lymphatic hyperplasia is the cause of the enlargement of the thymus. The true explanation probably is that the growth of lymphoid tissue in the body and that of the thymus happen to follow the same curve. There is much evidence to show, moreover, that after birth the thymus is simply a lymphoid organ without secretion.

One thing is certain, namely, an enlargement of the thymus, provided what is thought to be an enlargement really is one, does not necessarily indicate that a child has status lymphaticus. It must be emphasized again, moreover, that it is very difficult to determine from a Roentgenogram whether a thymus is enlarged or not. It is obviously irrational, therefore, since it is not known whether status lymphaticus is a cause of death or not, whether the thymus has anything to do with the etiology of status lymphaticus or whether the shrinking of the thymus has any effect in status lymphaticus, and since the thymus may be enlarged from other causes and the evidence afforded by Roentgenograms is not sufficient to prove that it is enlarged, to claim that every child that shows what is supposed to be an enlarged thymus with the Roentgen ray is in danger of sudden death. It is unreasonable to say, therefore, that every child should have a Roentgenogram taken before it is given ether or operated on in any way—have a paracentesis of the ear drum or a lumbar puncture, for example,—and, if the Roentgenologist thinks the shadow is larger than it should be, given Roentgen ray treatment. Nevertheless, this is just what was claimed by a Boston Roentgenologist in a broadcast a few weeks ago. It would be almost as reasonable to say that every child that is liable to be frightened or to fall down should have one, for children have been known to die suddenly under such circumstances.

It must be admitted, of course, that children have died unexpectedly under anesthesia and that some of these children have shown the pathologic changes of status lymphaticus. Many others have died under anesthesia that did not show these changes. The question at once arises as to whether the deaths in those that showed these changes were not due, as in the others, to improper anesthetization, prolonged operation or impaired resistance from infection. No one, of course, can tell. It must be also admitted that many children in the past, before the Roentgen ray was discovered, must have had thymuses which would now be considered enlarged and did not die under the anesthetic. Moreover, children that are said to have enlarged thymic shadows are now operated upon without injury. It is also true that children who have had Roentgen ray treatment before operations have not died. No one knows whether they would have died or not if they had not been treated. The probabilities are that they would not have died. The basis for this statement is as follows: It is claimed that 7% of all children under ten years of age have enlarged thymuses which demand Roentgen ray treatment before operation. There is no reason to suppose that enlargement of the thymus is any more common now than it always has been. It is certain that in the past 7% of the children under ten years of age who have been anesthetized and operated upon have not died. The operative mortality in the past, as in

the present, has varied with the skill and judgment of the operator and with the institutions at which the operations were performed. Treatment with the Roentgen ray before operation will not prevent death from improper anesthetization or prolonged and serious operations. Deaths have occurred, therefore, after Roentgen ray treatments. It is assumed, because the children had been treated with the Roentgen ray, that they were not due to status lymphaticus. Is it not just as reasonable to believe that the deaths that occurred in children that have not had Roentgen ray treatments are not due to status lymphaticus, but to improper anesthetization and poor operative judgment and technic? It would be neither polite nor politic to publicly advance the evidence in favor of this contention.

Having had no operative experience myself and fearing that I might be minimizing the frequency of the occurrence of death from status lymphaticus during anesthetization and operation, I asked a number of surgeons, whose experience with children had been large, how many deaths they had seen in children during anesthetization and operation which they thought were due to status lymphaticus. Dr. James S. Stone, Dr. F. P. Emerson, Dr. William F. Knowles, Dr. Harold Tobey, and Dr. George Tobey, whose names I am using with their permission, had never seen one. Dr. William E. Ladd had seen one in which there was no other evident cause. I also asked a group of five orthopedic surgeons and one general surgeon, how many they had seen. The orthopedic surgeons remembered two in which that diagnosis had been made. One of these children had been operated upon before, however, without any difficulty. The general surgeon thought that there had been two or three over a long series of years at the large general hospital with which he had been connected. They had not been his patients, however, and his knowledge of status lymphaticus seemed very vague. I also asked two leading Boston anesthetists what their experience had been. They said that they had never seen a death which they thought was due to status lymphaticus. They also said that they not only considered it unnecessary to take Roentgenograms of the thymus before operation, but that they did not fear to give an anesthetic, even if a Roentgenogram did show what was thought to be enlargement of the thymus.

It is evident from the experience of these surgeons and anesthetists that death from status lymphaticus as the result of anesthetization and operation must be a most unusual occurrence. There is much doubt whether the deaths that are attributed to status lymphaticus during anesthetization and operation are really due to it. There is no proof that enlargement of the thymus is the primary or causative factor in the pathologic complex described as status lymphaticus. There is no justification, therefore, for the assumption that shrinking of the thymus with the Roentgen ray will have any effect on status lymphaticus. There is much reason to believe that many of the Roentgenograms taken do not show the real size of the thymus and much evidence to show that it is very difficult to decide from a Roentgenogram whether the thymus is larger than it ought to be in the given child at the given time. It does not seem either reasonable or justifiable, therefore, to say that a Roentgenogram should be taken of every child before anesthetization or operation, that treatment with the Roentgen ray should be given in every case before anesthetization or operation, if the Roentgenologist thinks that the shadow is enlarged, and that the physician or surgeon who does not follow this course of procedure is negligent. Nevertheless, such statements are being made not only to physicians, but to the laity. However unjustifiable they may be, they place the conscientious physician, who wishes to do everything that is necessary for his patients, but also wishes to remain an honest man and to save his patients unnecessary expense, in an unfortunate position. At present, all that he can do is to explain the situation to his patients and let them decide what they wish to have done. He can be comforted, however, by the knowledge that this fad will wear itself out, as have so many others, and that common sense will again prevail.

THE USE OF SALICYLATES IN THE TREATMENT OF CHRONIC EPIDEMIC ENCEPHALITIS*

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SALICYLATES have an established place in therapeutics. Their curative effect in the rheumatic affections is well known, and needs no mention. That they may have a favorable influence on certain forms of encephalitis was not recognized until 1923, when Carnot and Blamoutier[3] in Paris treated two cases of acute epidemic encephalitis by intravenous injections of sodium salicylate. One case, of the choreiform type, recovered almost completely after a week of daily injections, and then relapsed when the injections were discontinued. The second case, of the lethargic form, showed excellent results under continued injections. Carnot suggested at this time that salicylate therapy would

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be worth trying in the chronic cases—the so-called sequelae. Barry[1] in the same year, made a thorough study of various therapeutic agents in epidemic encephalitis, reporting ten additional cases treated by intravenous sodium salicylate and pointed out the striking parallelism between the institution of salicylate treatment and amelioration of symptoms. He also mentioned the experimental work of Carnot and Harvier[5] in successfully neutralizing in vitro the encephalitic virus by contact with sodium salicylate.

The French literature abounds in reports of isolated cases of acute epidemic encephalitis treated by intravenous sodium salicylate with more or less success, (Rathery and Gournay[13]; Courceoux and Meignant[6]; Dénéchau and Barbary[8]; Bénard, Marchal and Bureau[2]; and others). While many authors mention the efficacy of salicylates in the treatment of post-encephalitic Parkinsonism, but few cases are reported in the literature. Vedel, Puech and Pagès[15] reported six cases which were treated by daily intravenous injections of sodium salicylate in doses of 4 grams in 10% solution. These authors admitted that the results were very doubtful, but insisted that since we are so deficient in treating cases of post-encephalitic Parkinsonism, we must not neglect the chances of relief that salicylates seem to afford. Tinel[14] employed sodium salicylate by mouth in doses of 6 to 8 grams per day for two or three days repeated every week or ten days, and reported "an arrest of the progress of Parkinsonism, a recovery of the general condition, and a more or less obvious regression of the nervous symptoms". MacBride and Carmichael[10] in London reported the results of three cases treated by intravenous salicylates; in two of them, the ability to write a legible hand returned and the rigidity was definitely reduced. These authors reiterate what many of the French school have said, (Barry, Carnot, Paulian) that the results are less successful in Parkinsonism than in the acute forms of encephalitis.

In order to determine the true position of salicylates in the treatment of Parkinsonism, studies were begun by the Neurological Service of the Boston City Hospital in the autumn of 1926. The cases treated are herein briefly reported.

The mode of administration has been described in detail by the previous workers. Barry pointed out that the intravenous method was best because gastro-intestinal irritation is thereby avoided; he believes that by the intravenous route the drug is innocuous, more efficacious, and more rapidly absorbed. He insists that only pure salicylate must be used; that is, "purified by recrystallization, in simple solution, colorless, neutral in reaction, non-effervescing with the addition of sulphuric acid, preserved in ampoules of uncolored glass". The intramuscular route, though less effective, was recommended by Courceoux and Meignant[7] when excessive venous thrombosis prevented the use of the veins. Oral administration was advised by Carnot as supplementary to intravenous medication. Intraspinal injection was used in one case by Courceoux and Meignant[6].

The dosage and dilution of the drug, employed by the previous workers, varied tremendously. Carnot used at first 50% solutions; then, due to local venous thrombosis, he used 10% solutions, and stated that "4% solutions are preferable". Others used from 2% to 30% solutions; some used isotonic glucose as the diluent. In some cases, 4 grams a day were given; in others, 1 gram per day in divided doses over long periods achieved the same effect. There is no unanimity of opinion, although most authors agree that the regularity of treatments, the continuity, the prolonged continuance after apparent regression of symptoms, and periodical repetition, are more useful than large dosage.

In our series of cases, a constant dosage of 2 grams (31 grains) of sodium salicylate contained in 10 cc. ampoules (20% solution), was injected intravenously at weekly intervals. Since most of the treatments were given in the out-patient clinic, it was not uncommon for patients to skip a week now and then, for one reason or another. In one case (No. 6), 2% and 4% solutions were employed, 100 cc. and 50 cc. respectively being injected to maintain the 2 grams dosage.

CASE REPORTS

CASE 1.—G. F., aged 20 years, was first seen on March 21, 1927. In 1920, he was in bed for four days with "influenza", from which he recovered completely. In the summer of 1924 he became very "nervous". The nervousness was exaggerated by emotional upsets and by exercise, and progressed until he was forced to give up his work as an office clerk, in December, 1925. At about this time he developed tremor, first in the right hand, then in the left hand, and finally, in the left leg and in the facial muscles, making speech very difficult. The general physical examination was negative. Neurological examination showed the following positive findings: There was rigidity of the facial expression, more on the left side than on the right. Speech was tremulous and stuttering. There was a coarse tremor of the left arm and leg, and "pill rolling" movement in the right hand. The tongue and eyelids were very tremulous. Left arm and leg were rigid. Deep reflexes were exaggerated, more on the left. There was marked sweating. The gait was of the Parkinson type.

This patient received seven weekly intravenous sodium salicylate treatments, supplemented by the usual hyoscine medication. Though the patient stated he felt much better, there was no objective improvement. Occupational therapy was tried with no relief. In June, 1927, he was given absolute rest for two months in the Brookline General Hospital, where he also received large doses of aspirin and hyoscine. He returned to the clinic in September, 1927, feeling much improved.

CASE 2.—T. R., a man aged 29 years, was first seen on January 19, 1927. He was perfectly healthy until March 1922, when he suffered an acute attack of encephalitis lethargica which lasted three weeks.

Since then he has never been well. He complained of weakness and stiffness of the extremities. Walking was slow and labored, and his movements were awkward. He also had aches and pains in various parts of the body, and suffered from insomnia. The general physical examination was negative. Neurological examination showed the following conditions: Both pupils were irregular and reacted sluggishly to light and accommodation; ocular movements in the upward and downward directions were diminished. The facial expression was mask-like. There was the typical Parkinson gait and posture. On the finger-to-nose and heel-to-knee tests there was considerable ataxia on the left side. The speech was monotonous. There was marked tremor of the tongue, eyelids and hands, and typical "pill-rolling" movement of the fingers of the left hand. The deep reflexes were equal throughout, but exaggerated.

For two months, from January to March 1927, he received physiotherapeutic treatment, baking and massage, with no relief. From February to May, he received fifteen intravenous sodium salicylate treatments at weekly intervals. At the end of this time, he was subjectively better and there was less tremor, but the stiffness was unchanged. From June to September he was given absolute rest in the Brookline General Hospital. Examination in October 1927 showed absence of tremor, good coördination of movement and less slowness of motion.

Case 3.—B. K., a man aged 26 years, was referred from the House Service on August 20, 1926. A year previously he suffered from drowsiness for a period of a few weeks. Shortly afterwards he developed stiffness and awkwardness of the arms, later of the legs, then a general slowing of his movements; subsequently there appeared slight tremor of the left hand. The general physical examination was negative. Neurological examination showed the following positive findings: There was left-sided stiffness, mask-like expression of the face, slight tremor of the hands, and monotonous speech. The stance and gait were Parkinsonian. There was also some mental depression.

Under occupational therapy and regular doses of hyoscine, this patient improved somewhat, and in December 1926, there was noticed less rigidity. In February 1927 he was started on salicylate therapy and received seventeen intravenous injections at weekly intervals. In July a severe mental depression interrupted further treatments. Neurological examination at this time showed distinct improvement. The facial expression was more animated, the tremor was very slight, and there was less stiffness in the gait.

Case 4.—A. F., a woman aged 40 years, was first seen on April 15, 1927. In 1918 she had an attack of "influenza", when she was "unconscious" for five days. She complained of drowsiness for about a year afterwards. Since then she had gradually developed weakness of the right arm and leg and some tremor of the right hand so that she was unable to hold anything. These symptoms became progressively worse. In 1926 she began to complain of pain in the right shoulder and upper arm, which was her chief complaint when first seen in 1927. The general physical examination was negative, except for hypertrophied tonsils and tenderness in the right deltoid region. Neurological examination showed a unilateral, right Parkinsonian syndrome, with tremor, weakness, and rigidity of the right arm and leg. Associated movements were absent in the right arm and diminished in the right leg. Deep reflexes were exaggerated in the right leg. There was a suggestion of the mask-like expression, and less movement in the right side than the left.

After a short course of hyoscine therapy, she was started on intravenous salicylate treatment in May, 1927. She has received thirteen weekly injections (October 3, 1927), and shows marked improvement. The pain in the right shoulder and arm has disappeared; the stiffness in the right arm is less; and she is now able to do her housework.

Case 5.—J. E., a man aged 40 years, was first seen on August 20, 1924. In 1922, he had acute encephalitis lethargica from which he recovered completely. One year and eight months later, he began to "slow down in his motions". This became progressively worse, and was soon followed by increased salivation and tremor of the hands. The general physical examination was negative. Neurological examination showed the following positive findings: The gait was slow, deliberate and with short steps. All the extremities showed muscular rigidity. The deep reflexes were very active, more on the right than on the left. Abdominal reflexes were absent. The face was completely expressionless. There was marked tremor of the tongue and slight tremulousness of the lips. The speech was slow and thick.

This patient received all the usual drug treatments. After six months of large doses of hyoscine and atropine, there was some relief of the drooling. From December 1924 to August 1925, he received electrotherapy twice a week, during which time he lost forty pounds in weight. From March 1926 to June 1926, he received 10 to 15 units of parathormone subcutaneously every other day, and 5 grains calcium lactate by mouth twice a day. For the next five months, he was treated with regular doses of hyoscine. There was no relief of symptoms; in fact there was progression.

In April 1927, the salicylate treatment was begun. During the following six months, he received ten intravenous treatments at approximately weekly intervals. There was some subjective improvement, and less shaking, especially for a few hours after the treatment. There was no change in the neurological signs. The drooling and the stiffness became progressively worse.

Case 6.—E. M., a woman aged 40 years, was first seen on June 24, 1925. In 1923, she had the "flu" with prolonged weakness. Two years later, she gradually developed a tremor of the left arm and leg. She became very "nervous" and complained of dizziness. The general physical examination was negative. Neurological examination showed a coarse tremor of the left leg and "pill-rolling" movement of the fingers of the left hand, marked rigidity with loss of associated movements on the right, and slight facial immobility.

After courses of hyoscine, physiotherapy and a trial of bulbocapnine, intravenous sodium salicylate was started. In October, 1926, four bi-weekly injections of 100 cc. of a 2% solution were given. After two injections the patient volunteered the information that there was much less tremor. After the third the tremor was practically absent, but she complained of slight buzzing in the ears. After the fourth the tremor was definitely absent. When seen five days later the tremor was as bad as ever. From November, 1926, weekly injections of 50 cc. of a 4% solution were given. There was marked improvement for four days after each injection. In the words of the patient, "I would feel much better for a few days after the treatment, then the nervousness and shaking would come back again."

Case 7.—E. K., a girl aged 23 years, had "sleeping sickness" in 1923, when she was a patient in the Boston City Hospital for three weeks. Shortly afterwards she began to complain of trembling all over the body, and general nervousness. She was again seen in August 1927. The general physical examination was negative. Neurological examination showed

the following: The left pupil was greater than the right; both reacted sluggishly to light and accommodation. The right eyelid was slightly drooped, and the left internal rectus muscle was weak. There was the typical mask-like face. Voluntary movements were slow and awkward. There was considerable tremor of the extremities, the head, tongue, and eyelids. The deep reflexes were hyperactive throughout.

Six intravenous injections of sodium salicylate were given at weekly intervals. The patient stated that the tremor diminished after each treatment, the improvement lasting a day or two. The treatments were discontinued because the patient developed phobias and other psychotic manifestations, necessitating her removal to a sanitarium.

CASE 8.—J. S., a man aged 42 years, was first seen on November 10, 1925. During the epidemic of 1917-1918, he suffered from a prolonged fever. Shaking of the head began at this time; in 1923, the hands and legs began to tremble; these symptoms steadily progressed. When first seen in 1925 he also complained of general malaise, aches and pains, and insomnia. The general physical examination was negative, except for diminished hearing in the left ear due to an old otitis media. Several neurological examinations made over a period of two years, from 1925 to 1927, showed the following conditions: There was a coarse tremor of both hands which persisted on intention, and rhythmic nodding of the head. The gait was stiff, with diminished associated movements of the right arm. The right biceps reflex was increased and both knee jerks were diminished. The speech was monotonous, and the face was slightly expressionless.

From November 1925 to September 1927 physiotherapy combined with hyoscine medication was employed, with no relief of symptoms. After four weekly intravenous injections of sodium salicylate the patient stated that the shaking of the head had definitely decreased, and the aches and pains had disappeared. To determine whether any psychic effect was present, normal saline injections were given. During this time, the patient volunteered the information that he did not feel as well as before.

CASE 9.—H. J., a man aged 24 years, was first seen on November 17, 1926. In the epidemic of 1918, he suffered from an attack of influenza. For several years, he had periods of drowsiness. In 1921, and again in 1926, he contracted gonorrhea. In 1921, following a slight injury to the right shoulder, the patient first noticed that he could not write legibly on account of tremor. Later he noticed a slowness of the movements of the right arm and leg, and he became gradually more "nervous". The general physical examination was negative. Neurological examination showed the following: There was the typical mask-like facies; voluntary movements were slow; and associated movements were diminished on the right side. There was right-sided rigidity, weakness, and hyper-reflexia, and a static tremor of the right hand increased on intention.

The usual hyoscine treatment was tried with no relief of symptoms. Eight intravenous injections of sodium salicylate were given at weekly intervals. No favorable effects were observed, and the symptoms progressed steadily.

CASE 10.—E. J., a woman aged 44 years, was first seen on April 29, 1925. She had had measles, diphtheria and scarlet fever in childhood, and "heart trouble" for sixteen years. In 1923 she suffered from the "grippe". Since then she complained of a twitching of the head to the left, especially when walking. She experienced some stiffness in walking, and at times a tremor of the hands. She also noticed gradual mental sluggishness. The general physical examination revealed mitral stenosis and regurgitation, and auricular fibrillation. Roentgenograms showed hypertrophic arthritis of the cervical spine and clouding of the left antrum and ethmoid. Neurological examination showed: mask-like facial expression and stiffness of the neck; there was a fine tremor of the eyelids, lips and tongue; and marked rigidity of the arm muscles with lack of associated movements of the left. The reflexes were normal except for exaggerated knee jerks.

This patient at first received the usual hyoscine medication. Physiotherapy was employed from June to November 1925. Then parathormone was tried until March 1926, with no relief. Occupational therapy was next tried. From December 1926 to September 1927, she received thirteen injections of sodium salicylate at irregular intervals. The patient, seen in September, reports no relief from her symptoms.

CASE 11.—M. H., a woman aged 44 years, was seen on March 31, 1927. She had had "influenza" in 1918, from which she recovered completely. Late in 1926, she gradually developed a tremor of the hands, causing her to quit her work as housekeeper. Two months later, she began to have difficulty in walking. She complained of dizziness and general "nervousness." The general physical examination was negative. Neurological examination showed the following positive findings: There was considerable tremor of the hands and tongue and tremulousness of the eyelids. Speech was monotonous; the deep reflexes were hyperactive throughout; the gait was stiff and there was loss of associated movement in the right arm. The pupils were slightly irregular and reacted sluggishly to both light and distance.

She received eight intravenous injections of sodium salicylate at weekly intervals. No improvement was noted, and the Parkinsonian symptoms progressed. This patient is now in the Long Island Hospital for chronic diseases.

CASE 12.—F. H., a boy aged 15 years, was first seen in the Surgical Clinic on July 18, 1927, on account of stiffness of the left knee. He had had "sleeping sickness" in 1920, when he was "unconscious" for ten weeks. Since then he had been nervous and irritable, and had suffered a marked change in personality. The general physical examination was negative except for a stiff left knee. Roentgenograms showed a slight irregularity of the epiphyseal line. Neurological examination in September 1927, showed the following: Facial expression was slightly slow and stiff; voluntary movements were slow; there was marked rigidity of all the muscles; speech was slow and monotonous. There was evidence of vasomotor instability and of marked personality disorder.

On account of the patient's poor co-operation, only three treatments of intravenous sodium salicylate were given. No effect was observed.

COMMENT

The above histories are but samples of the many cases of Parkinsonism treated in our clinic, and indicate that we are still groping in the dark for an effective remedy. It is apparent that these patients received little or no benefit from salicylate therapy. Subjective improvement was noted in nearly every instance, but the psychic element was probably large. Of the twelve cases here reported, only three (No. 4, 6 and 8) appear to have been improved by the treatment and in them the improvement was only temporary. The progress of the disease does not seem to have been arrested appreciably, although a single year's observation is not al-

ways sufficient to detect the slow progression of Parkinsonian symptoms. Case No. 9 illustrates that the disease progressed in spite of salicylate therapy. Local venous thrombosis, as noted by the French, occurred at one stage or another in every case. This could be avoided by giving the drug by mouth and it would seem that frequent large doses given by the oral route might be more effective than weekly intravenous doses because of their continuity of action.

The rationale of salicylate therapy in acute and chronic forms of encephalitis is not clear. Whether it is a specific or general anti-infectious agent is not known. It probably has been effective in some acute cases reported by the French. Their careful observations indicate that the following sequence of events occurs in the acute cases treated by salicylates: first, the infectious signs disappear; then, in turn, neurological signs, restlessness, myoclonic movements and headache. Such treatment given early may prevent the development of Parkinsonian symptoms, but, since cases have not been followed for long periods after the acute stage, this cannot be looked upon as proven. The conception of a persistent chronic infection existing in Parkinsonism, as recently advocated by Freeman[9] is now generally conceded. It is possible that persistent treatment of salicylates during and after the acute stage may prevent the development of the chronic stage, of which Parkinsonism is but one phase.

CONCLUSIONS

1. There has been no striking benefit from intravenous injections of sodium salicylate in our cases of chronic encephalitic Parkinsonism.

2. On account of local injury to the veins, it is suggested that the oral method of administration of salicylates be tried in the future.

3. There is evidence that acute epidemic encephalitis is benefited by salicylate therapy.

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THE U. S. MARINE HOSPITALS AND AMERICAN MERCHANT SHIPS

Reports recently submitted to Congress indicate that at no time in the past 129 years has the medical aid furnished by the Government, through the United States Public Health Service, to American merchant vessels been of greater value or more necessary than at present to keep the flag on the seas. This is the oldest function of the U. S. Public Health Service, the Bureau under which the marine hospitals are operated; in fact it was for this specific purpose that the Service was organized under the Act of July 16, 1798.

For more than a hundred years the medical relief stations now operating in 152 ports of the United States and its insular possessions, have been the refuge of sick and injured sailormen. During the past year there were 356,746 applications for treatment or physical examination; 1,288,061 hospital days of treatment were given, and 632,341 out-patient treatment supplied. It is obvious that in supplying this medical care, the majority of which was for merchant seamen and otherwise presumably an obligation of the ships, the Government is supplying a tangible, although not very costly, assistance to its merchant fleet.

Many merchant seamen are still living who contributed directly from their wages to the Marine Hospital fund in accordance with laws extant previous to 1884, when direct levies were discontinued and other funds provided by Congress. Inquiries are sometimes received from seamen and their friends as to the disposition of this fund and the relative amounts collected and expended by the Government. The tax collected from each seaman by the customs officers was 20 cents per month from 1799 to 1870 and 40 cents per month from that time until 1884, and the aggregate of all such collections was $15,794,807.63. During the same period $16,153,592.14 was spent for maintenance of marine hospitals and other relief stations for the treatment of merchant seaman, and $3,468,779.73 for new construction and repairs. It is of interest to note that the tonnage tax first levied on American and other ships in 1884 and for a number of years thereafter devoted to the maintenance of the marine hospitals still yields to the Federal treasury a considerable revenue, amounting in 1927 to $2,222,223.01.

At the request of the Department of Commerce examinations of the vision and color vision of all pilots, masters, mates, and engineer officers on merchant vessels have for many years been made by officers of the Public Health Service. To this requirement has more recently been added the instruction and examination in first aid to the injured and emergency treatment of disease. The personnel of the U. S. Coast Guard, numbering about 11,000 officers and men, are beneficiaries of the Public Health Service which also details medical and dental officers for duty aboard the cruising cutters and at important section bases. Injured employees of the Federal Government, who are patients of the U. S. Employees' Compensation Commission, are also beneficiaries and constitute about one-fifth of the total clientele which has recently been increased by the Longshoremen's and Harbor Workers' Compensation Act, affecting approximately 400,000 longshoremen and harbor workers. More than 103,000 physical examinations not related to treatment were made last year, of which 22,090 were for applicants seeking Civil Service positions. The Government is the largest employer of labor and in keeping with the accepted relationship of employer and employee it pays compensation for disabling injuries. It also provides for retirement with pensions for employees grown old in its service. Physical examinations are therefore necessary.

The proposed new 250-bed marine hospital at Cleveland, which is designed also to accommodate patients of the U. S. Veterans' Bureau in that port, will be bulit out of funds derived from the sale of the present site which in 1837 cost the Government $12,000 and a portion of which was recently sold for more than a million dollars.

NEW ENGLAND MEDICAL COUNCIL

Harvard Club, Boston, Mass., November 4, 1927

A MEETING of the New England Medical Council was called to order by the President, Dr. David W. Parker, of Manchester, N. H., at 11:40 A. M.

The following named members were present:

Dr. David W. Parker (in chair), Manchester, New Hampshire.
Dr. John M. Birnie, Springfield, Massachusetts.
Dr. James S. Stone, Boston, Massachusetts.
Dr. Thomas W. Luce, Portsmouth, New Hampshire.
Dr. Bertram L. Bryant, Bangor, Maine.
Dr. William Ellingwood, Rockland, Maine.
Dr. George C. Wilkins, Manchester, New Hampshire.
Dr. Frank H. Wheeler, New Haven, Connecticut.
Dr. Robert L. Rowley, Hartford, Connecticut.
Dr. Lucius C. Kingman, Providence, Rhode Island.
Dr. Herbert F. Twitchell, Portland, Maine.
Dr. Herbert G. Partridge, Providence, Rhode Island.
Dr. Arthur H. Harrington, Providence, Rhode Island.
Dr. Kendall Emerson, Worcester, Massachusetts.
Dr. Emery M. Fitch, Claremont, New Hampshire.
Dr. Walter P. Bowers, Clinton, Massachusetts.
Dr. Franklin G. Balch, Boston, Massachusetts.

The Secretary, Dr. Bowers, stated that the minutes of the last meeting had been sent to the members in regular form and published in the BOSTON MEDICAL AND SURGICAL JOURNAL, and upon motion duly seconded, it was

Voted that the reading of the minutes be omitted.

The Secretary called the attention of the members to the fact that it had been decided to publish the proceedings of the Council regularly and stated that it was necessary that the Secretary should have the coöperation of the members in the way of correcting and revising the copies sent to them of the stenographic report of the discussions, and asked the members to attend to this detail as promptly as possible and return the reports to the Secretary.

The Secretary stated that the Committee on Finance of the Massachusetts Medical Society had arranged to present to the next Council meeting a recommendation for the appropriation of a certain amount of money to meet the expenses of the delegates to these meetings, and that it was a general impression that a plan should be adopted for the arrangement of meeting the expenses by an equal distribution of the expenses to the different States so that the men coming from Vermont and Maine should not pay any more for the expense of coming to these meetings than the men who happen to be in Massachusetts at the time a meeting is held in Massachusetts. If this recommendation is adopted the money will be available in the winter. He stated that so far as Massachusetts men are concerned he felt they would all be very ready to meet their proportionate part of the expenses and they will be reimbursed when the appropriation is made by the Society.

The Treasurer reported that the returns for the statements of expenses have been very generally made and there is only a small deficit at the present time, amounting to $5.37, which the Treasurer is very glad to carry until some future time.

The Secretary read the following communications:

(Telegrams from Drs. Duncan, and Brown and letters from Drs. Sullivan, and Blumer, regretting inability to attend the meeting.)

The President called upon Dr. Stone for the report of the committee appointed at the last meeting to go over the discussion in regard to distribution of physicians and to bring in recommendations.

DR. STONE: *Mr. Chairman.* Your committee consisted of one representative from each of the different States. A provisional draft of a report was sent to each member and they were asked for comments. Suggestions were received from Drs. Gilbert, Wilkins, Brown and Blumer. Three members of the Committee have considered and incorporated them in a report which is presented for discussion. Will you hear the comments first, last, or not at all?

DR. WILKINS: As the final report incorporates practically all of those suggestions in a plainer form, it would save time to read the report.

Dr. Stone felt that Dr. Blumer's comments should be read in their entirety, and read his letter before the reading of the report of the Committee.

COMMITTEE REPORT

The creation of a Commission on Medical Education and of a national committee on the cost of Medical Service shows a widespread doubt as to the effectiveness of present day Medical Education and a profound distrust of the economic conditions of modern medical practice.

No body representing the Medical Societies of any section of the country can properly anticipate the work undertaken or speak with the authority rightly due these two commissions. But conditions are such as to make it seem appropriate for the New England Medical Council to offer certain opinions and suggestions. The medical profession has an interest in the standards of medical education.

The increasing dearth of physicians in rural communities is in great part the result of the shift in population from the small to the large town.

Certain factors tend to compensate for the loss of the local physician in the small village. These are—

1st. Better roads and roads kept open in winter, and better telephone service.
2nd. Increasing numbers of Community Hospitals.
3rd. Better nursing service.
4th. More efficient modern medical service.

The distribution of physicians in rural communities might be improved by the interested coöperation of Boards of Registration and Medical School authorities, the former giving information regarding the needs of rural communities, the latter interesting themselves in the location of their graduates. Hospitals also might help.

Economic conditions make it impossible for a physician to live in some of the smaller communities. The increased cost of Medical Education is one but not the chief of these factors. The decrease in the number of medical students is another. The larger opportunities for practice according to high standards in a town with modern hospital facilities is an important factor today, as compared with the relatively equal facilities for a satisfying practice in country or city but a few years ago.

An adequate income and reasonable hospital facilities are essentials if a community is to maintain a resident physician of high grade. Fees commensurate with the grade of service rendered and remuneration by the community for work in public health and preventive medicine are essential, as is available hospital service.

Adequate remuneration for better personal and community health is the best possible investment of money. The loyal support of the resident physician by the citizens of any rural community along the lines mentioned is essential.

The conditions of medical practice are in general beyond the control of medical schools. But the cost of medical education and the direction given to the training of students is in the main definitely in the hands of Medical Schools. The limit set upon the admission of applicants to Medical Schools is of greater apparent than real importance owing to duplication of application.

The marked decrease in the number of Medical Schools, the limitation in enrollment and the elevation of required standards have materially affected the number of physicians engaged in rural practice.

Increased medical knowledge, greatly improved teaching and training and the advancement of the laboratory have inevitably increased the cost of medical education. But of recent years medical research has assumed tremendous importance. The need and benefits of research are not questioned, nor is the need of an understanding of research by medical students. Great foundations and rich endowments have properly fostered research. The question is whether research, particularly in the laboratory, has not assumed too great an importance in medical education and whether the two have not been too closely mingled. Laboratory research in the preclinical sciences particularly has assumed undue importance.

The pre-clinical years should give the student a good idea of the philosophy of the pre-clinical sciences in their relation to clinical medicine rather than make finished physiological chemists or pathologists of the medical students as a whole. Certain of the pre-clinical studies might be given in the colleges rather than the medical schools.

Information as to the proportion of the cost of research in medical education is not readily available. The importance placed upon research has been a tremendous handicap upon those schools not favored by great foundations, regardless of their record of achievement in the training of physicians. An arbitrary limitation in the number of students admitted to medical schools has been established.

Research undertaken by the ordinary medical student can be justified solely as a method of education. It cannot be justified on the grounds of economic efficiency.

Teachers are today selected in great part as a result of their productivity in research. In general the emphasis placed upon research in the laboratory has tended to divert the mind of the student from the study of the individual patient. Yet the field for the advancement of knowledge by clinical study is boundless. Every clinical department should have among its teachers at least one expert clinician holding high academic rank.

The required specialization in premedical studies is a recent development and is doubtless proven wise by the results attained by stduents. But this does not prove that the present medical curriculum is the best. There are grave doubts as to whether premedical and medical teaching are not being too closely confined and too thoroughly "standardized." Each medical school should be able to develop along its own lines within reasonable limits and greater elasticity be given in the curriculum by the reduction of the amount of required work.

The individuality of medical schools has been impaired by the power concentrated in the great foundations. Such power naturally may fall into the hands of one person.

It is felt that the training of able physicians, keen in observation and clear in thinking, must always be the primary aim of a medical school. Such physicians cannot fail to advance knowledge and benefit the community and perhaps the world by their work.

The training of specialists in clinical and research lines is a matter of great but of different importance.

The New England Medical Council offers these suggestions.

1st. A less rigid separation of the basic or preclinical medical sciences from the clinical studies and a bringing of these pre-clinical studies into relation with clinical medicine. Students should come into close touch with patients earlier in the course.

2nd. The radical limitation of required research by the ordinary student in pre-clinical studies and a limitation of required research in the clinical subjects to what is essential for a broad education.

3rd. Simplification of teaching by less attention to the changing technical details particularly in the specialties and by better grounding in the fundamental principles of physiology and pathology, not neglecting incipient pathology in relation to clinical medicine.

4th. Training in a specialty must be based on adequate general ground work. The usual four years in the medical school is sufficient only for a broad general medical education.

5th. The recognition of the importance of physical therapeutics.

6th. It is earnestly hoped that the Dartmouth Medical School be placed upon a four-year basis.

7th. A recognition of the interest of the Medical profession and of the community in medical education and the distribution of physicians.

DISCUSSION

DR. BIRNIE: Did you mean to omit the question of reopening of Bowdoin Medical School?

DR. STONE: Dr. Bryant, Dr. Williams and Dr. Kingman seemed to feel that it was probably wise not to mention Bowdoin in the report because there did not seem to be any active interest in Maine at present to reopen Bowdoin. That is a matter for discussion. Dr. Twitchell is here. I don't know what he would say.

DR. PARKER: Dr. Twitchell, have you anything to say in regard to Bowdoin?

DR. TWITCHELL: I hesitate to say anything on the subject because for a long time I haven't

thought about it. Having considered that for the time being the question of a medical school in Maine is dead; but a good many of us have been hoping that it would sometime be revived.

One trouble, I think, in starting the Bowdoin Medical School again is that the classical faculty has never favored the connection of the medical school with the classical institution. I rather think that they have quite a donation from the medical school that they are using for other things*, but I don't know whether that could be brought back to help sustain a purely medical school or not. I have felt that it was a very unfortunate thing that the Bowdoin Medical School was closed because it has had on its faculty some quite noted men in the past and it has had a good representative alumni. The trouble is it would take a good deal of money, more perhaps than a good many of us in the State feel the State can afford to appropriate, to start the medical school again so that it could compete in any kind of a way with the big institutions which have their big foundations.

I might say while on my feet, that I believe that the medical education of the medical student is overdone and takes too much time and costs him too much money and that it was perhaps a mistake when the American Medical Association made the pronouncement for the Class A schools. I think it is a very desirable thing that there should be some schools reëstablished on about the basis Bowdoin was on a few years before it was closed, but as for speaking authoritatively about the prospect of reopening it I am not competent to do it.

DR. PARKER: I have always felt that the smaller medical school had a distinct place in our scheme of medical education and I still feel very sorry that it has been necessary for Bowdoin and Dartmouth to be forced to give up their granting of degrees. As to whether it would be of any advantage to incorporate in a report of this sort the sentiment of a representative body of men for the reëstablishment of Bowdoin is a question that is open for discussion. I would like to hear from Dr. Bryant.

DR. BRYANT: I, with several others, went through the fight when the school was discontinued. There was no question at that time but that the trustees of Bowdoin College wished to eliminate the medical school because they had to advance money from the classical department to help support it. Then there was also the feeling among the faculty that they wished to make Bowdoin distinctly a classical institution. When it came to the matter of legislation, there were two factions among the physicians themselves, one of which would set the endowment for a school of that sort at so high a limit that it would be absolutely impossible for the State to carry it on, and another that wished to continue the school under any conditions if they could get an appropriation. Finally, there was the decision of the A. M. A. that the school should be put in Class B. at a certain time. I think it was a mistake to cut out the Bowdoin Medical School and would be very glad to see the school reopened if it could be financed as it should be. Personally, without outside help I can see no possible hope of the school ever being reëstablished. There is a fund of about $250,000, the income of which is distributed in scholarships for worthy medical students in other schools.

DR. STONE: As originally drafted the report included a clause—"It is earnestly hoped that the Bowdoin Medical School may be reopened and the Dartmouth Medical School be placed upon a Class A basis."

DR. WILKINS: As a member of the Committee I would say that the Bowdoin Medical School was left out of the report because of the fact that there was no tangible expression on the part of any one in the last year or two for opening Bowdoin again, while Dartmouth was in a different position. There has been a considerable amount of discussion and investigation toward increasing it from a two-year to a four-year course.

DR. PARKER: Would it be a perfectly fair way to put it up to the State of Maine members as to whether they wish it to go into the report or not. Do you wish it?

DR. BRYANT: I am willing it should go in.

DR. BIRNIE: I think possibly any report from this Committee may have quite a bit of weight; so we hope, at least. It seems to me that on this question of Bowdoin and Dartmouth we should first decide whether we are recommending this on pure sentiment which we have for those two schools, or whether we are recommending it as purely an investigative idea. It seems to me there would be only two justifications for recommending the opening of any school; first, that we haven't facilities enough for the men who wish to study medicine and second that it could be an experiment in education, that could carry out some ideas in connection with the modern trend of teaching. There would be only those two justifications. Dr. Stone referred, I think, to a report of Dr. Myers. I am not sure of the man, but I read in the last report of the meeting held in Chicago an article in which the author referred to the fact that there seemed to be a great many students who were not admitted to medical schools. He further said that there is practically no dearth in the facilities for medical education; that it is true that these men do register in different schools, but of course they can only go to one; that there is quite a percentage who fail of admission and that that percentage was very largely due to the fact that they were not properly prepared. I think his final conclusion was that there was no real dearth in the educational facilities of the country in regard to medicine. I think we ought to take both of these contentions into consideration before we recom-

*I understand some of the income is used for medical students who will come back to Maine after graduating from other state schools.

mend that these schools be reopened. Before we had this reorganization there were about 160 medical schools in the United States and today there are less than half of that number—about 80. As I remember it, there are only about 5 schools which are under Class A and those were around Class C and could not be brought up to Class A standard without much difficulty. Before we recommend that Dartmouth and Bowdoin be opened we ought to consider whether there is a real need of them. The public will support anything for which it believes there is a real need.

DR. BOWERS: I think perhaps there is one other question which might be considered with reference to that whole problem and that is the possibility of providing medical practitioners for remote communities through such educational institutions as Bowdoin and Dartmouth. It is of course recognized that a good many men who were formerly educated in Dartmouth and Bowdoin migrated from New Hampshire and Maine, thinking there were larger fields in other states, but I think a certain proportion—perhaps a small proportion—of the graduates from those schools did settle in the States in which the schools are located. You are all familiar with the survey made by Dr. Gile a few years ago in which he shows that the average age of the practitioners, in New Hampshire, for example (and I think a similar report has been made for Maine, perhaps not so comprehensive as the one by Dr. Gile,) and that was substantiated by the report of Dr. Lord, was very much beyond the middle age, well up toward 60 or in that vicinity, so that the probability of these specially educated men locating in the more remote districts of those States was becoming problematical, to say the least. The gentlemen who represent those States know better whether that contention still is logical and whether the improved conditions of travel have done away with the necessity of providing more doctors in smaller places. We hear that matter brought out very contentiously in discussions on this subject and so I speak of that in addition to the two points made by Dr. Birnie.

DR. BIRNIE: I agree absolutely with Dr. Bowers that there is probably a dearth of physicians in rural districts and I can say a word or two about Western Massachusetts. I know it is always questionable to make statements on general ideas and not on actual facts, but our impression in the western part of the State is that as a rule the men settle near the place where they have had their interneship. A man comes to Springfield from a college some distance away and takes an interneship in the Springfield Hospital. At the end of that time he looks around for some place near or even in Springfield, and nearly all our younger men are not residents of Springfield or even from nearby towns but they are ex-internes of the Springfield Hospital. There are a number of good locations for a young man within a radius of 40 miles of Springfield. We talk with those chaps as they get through and we can't get them to go to those places even within 40 miles of Springfield. I think it is a question of living conditions, and I don't believe personally that the smaller schools are going to help us in any way in regard to supplying the deficiency in the smaller communities.

DR. PARKER: In line with Dr. Birnie's remarks I think I am right in stating that a large proportion of the men who have come to New Hampshire since Dartmouth has not been giving degrees have come from the University of Vermont, a school of the same type as Dartmouth. That may be significant, and it may not. In regard to what Dr. Birnie says about interneship, I had my attention called within a day or two by Dr. Horace Stevens to a man who had come to Manchester to practice, a graduate of the University of Vermont, who had been an interne at the Cambridge Hospital. So you see they do come back into New Hampshire, even from the Cambridge Hospital.

DR. EMERSON: The question, I believe, is as to whether these few words should remain in the report?

DR. PARKER: Yes; and in general I think we should have a discussion of this whole report also.

DR. EMERSON: I think we ought to take into our consideration the attitude of the faculty and trustees of Bowdoin College. As I understood from one of the physicians from Maine, the attitude of the faculty is against the idea of reëstablishing the medical school there. It seems to me that under those circumstances it might perhaps not be particularly appropriate to recommend that, unless it came as a request from those members of our body who come from the State of Maine, as was suggested by the chair.

DR. TWITCHELL: I agree with what the gentlemen has just said, that it would perhaps be unwise for us to recommend the reëstablishing of the medical school in Maine at this time wthout more knowledge as to the attitude of the Bowdoin faculty or the faculty of the University of Maine, where it has been suggested it might be established.

DR. BRYANT: I agree with that.

DR. ROWLEY: As an administrative officer of the Connecticut Medical Examining Board I have had a little opportunity to observe the trend of young men in medicine in the matter of choice of locations, and I think there is a great deal in what Dr. Birnie has said, that the men are apt to locate in the town where they have had their interneship or some place nearby, or if they don't do that, in my discussions with them about some place where there seems to be a good opening for a physician, one of the first inquiries is: Is there a hospital there, or how near is there a reasonably good hospital? They

all want to get in locations where if they cannot be on the staff they can be in close enough contact so that they can take their patients in and run in and look after them and have the opportunity of hospital study and observation. It is not clear to me how the opening of smaller medical schools, as they have been referred to, or schools with less high standards than those we now favor, is going to in any way meet the situation that we find in the small towns. It seems to me that one of the most likely conditions that will tend to meet that situation is the establishment of hospitals in those communities that can serve a group of small towns, and that the establishment of such hospitals, however small they may be, will serve as an attraction to the young men who are well educated to go to those places, with the feeling that they can keep abreast and in touch with scientific developments. I have an open mind on this question, but it is not clear to me how any lowering of standards or opening of smaller medical schools is going to meet the situation.

DR. PARKER: I don't think the Committee or any men here wish to have it inferred that we wished to lower the standards. For example, Dartmouth has always endeavored and I think they have always maintained as high a standard as any school. They may not have had the research laboratories and research workers that schools like Harvard and possibly Yale have, but from a clinical standpoint they have maintained a strictly Class A standard and would never open up the school to grant degrees unless it was on that basis. I would not favor personally, and I think I speak for the rest of the men of New Hampshire, the re-opening of the Dartmouth Medical School to grant a degree of M.D. except on a strictly Class A basis.

DR. PARTRIDGE: It seems to me the whole problem is not the small community. It is a matter of psychology on the part of the young men. As I talk with the young internes who have had up to date training, their ambition is that they want to be connected with hospitals and we men in hospitals urge them to get on the staff of hospitals because it keeps them in touch. You see more in a year in a hospital than in five years of private practice. Rhode Island is a small State but I know two communities where there have been doctors who have done a large practice. In one community there was a doctor who had been there a good many years. Just at present there is a small town with one elderly doctor, a man who doesn't want to work very much. A man who was recently there has died and there is a good opportunity for a young man, but I doubt if you get any of our young internes to go there. Until we can make those young men see that perhaps in the long run they are just as well off in the smaller communities, we cannot solve the problem. I think, after all, there is a certain mercenary consideration. These men come to the cities and hear the men speak about their fees, and they know they cannot get any such fees in the country; but on the other hand perhaps a man at the end of his life in the country is just as well off as the man in the city with a much higher overhead.

DR. STONE: Shall we leave out the clause with reference to Dartmouth and Bowdoin altogether?

DR. PARKER: I personally would like to see the clause about Dartmouth go in, as a New Hampshire man, but it is simply a personal wish.

DR. WILKINS: I think it was at my suggestion that the Dartmouth clause was put in in the first place, and I had in mind the investigation that our committee in the State of New Hampshire made during the past year.

DR. EMERSON: I understand also that there was an expressed desire on the part of Dartmouth to do so if they could finance it; but there is not an expressed desire on the part of Bowdoin, as I understand.

It being decided to take up the five specific recommendations in the report separately the following action was taken:

Recommendation 1. On motion duly seconded it was voted to accept the recommendation.

Recommendation 2. Motion duly seconded to adopt the recommendation.

DISCUSSION

DR. BALCH: How much more of research is carried on than is desirable? I know the men get more clinical work than when I was in the medical school, but I don't believe in all places that that has been generally increased.

DR. STONE: I know it has increased. Of course the prescribed clinical work that we got was not as much as they get now, but the voluntary clinical work we got around the hospitals all through the school made it more, I think.

DR. BALCH: They have a great deal of time for voluntary work and they do put it in.

DR. STONE: I think Yale requires a research problem of every student.

DR. BOWERS: I think this is a matter of considerable importance because it may influence to some extent the amount of money which is devoted to research in medical schools. I have heard Dr. Edsall of the Harvard Medical School say on more than one occasion that the amount of money which is appropriated for research work is out of all proportion to that appropriated for clinical work. I think Dr. Balch recognizes that?

DR. BALCH: Yes; unquestionably.

DR. BOWERS: And the sentiment has seemed to be among those who contribute funds for medical endowment to specify that certain amounts shall be for research. Possibly they have an idea that there is an unplowed field and if you can only put money enough into it you

will dissolve all the fogs which surround the mysteries of medicine; in other words, that just beyond us there is a possibility of finding out all the mysteries with which we are confronted at the present time. And so people are inclined to give money to educational institutions for research. They wonder why doctors don't know the cause of cancer and they think, if they can put money enough into investigation that knowledge will be supplied. So I think we should have a certain element of sympathy for our educators in that they are confined to some extent to the amount of money which is specifically given for research purposes. While I am thoroughly in sympathy with this recommendation, I think we ought to realize that the hands are to some extent tied so far as the people who control the destinies of the medical schools are concerned.

DR. ROWLEY: I would inquire if the object of this section is to limit the amount of research work required on the part of students.

DR. PARKER: I take it that it is.

DR. STONE: That is the ordinary student; the man who wants to go into research should have every chance; but we are considering the amount of required work on the part of the ordinary student.

DR. ROWLEY: Would it be possible to insert the word "required" before research, in the first line? I think that would make it a little more clear. I would make that suggestion for discussion.

DR. STONE: The committee would accept that. It is not intended to limit the work of the exceptional student, but to cut down the research of the ordinary student and limit it to what is necessary to give him a decent education,—that is, a knowledge of the methods of research and the purpose.

A vote being taken, the motion was adopted.

Recommendation 3. Motion to adopt the recommendation, duly seconded.

DISCUSSION

DR. PARKER: That seems to be based on the assumption that physiology and pathology and incipient pathology are subordinated somewhat to other technical details.

DR. ROWLEY: Is that pretty generally true?

DR. BIRNIE: Yes, it is.

DR. EMERSON: That wouldn't mean very much to me as a man who doesn't do any teaching. Just what does the technical details refer to?

DR. BIRNIE: About twenty-five years ago there was a great deal of talk about the opsonic index and students were taught to do it, at the expense of a great deal of time, and today who ever hears of an opsonic index? This is one instance and there are numerous others.

DR. EMERSON: You mean they are sent to the laboratory?

DR. BIRNIE: Yes. You hear much today about blood sugars and blood nitrogen content. The fact is the men will never conduct those experiments or make those examinations. They will send that work to a laboratory. It is the changing technical details that we are talking about.

A vote being taken the recommendation was adopted.

Recommendations 4, 5, and 6.

Upon motions duly seconded these recommendations were adopted.

DR. BIRNIE: I would like to raise one more question. I have been under the impression from what I have seen myself and from reading those articles from the Chicago meetings on education that possibly too much time is spent in the medical school on the specialties.

DR. BRYANT: The student tries to be a specialist before he gets out of school; that is one of the criticisms we hear in the medical world.

DR. BIRNIE: You speak of that in one of the recommendations or in the report but I think it should be a recommendation in some form.

DR. PARKER: I agree with you on that.

DR. EMERSON: I think it ought to be worded with extreme care. We had a meeting in Worcester the other night on this same general subject and Dr. Rushmore brought out this fact and criticised us rather severely, and one or two general practitioners and surgeons backed him up, and then we had an avalanche of attacks from the specialists. We have got to be a little bit cautious in regard to getting into trouble with them. We don't want to antagonize them, and it is possible for the length of time it takes to become a specialist they may have some argument on their side. If a man has a particular desire or interest in one branch—perhaps a narrow branch—he may perhaps incidentally develop that interest the first year in the medical school. I can see that he might have an argument. I think that such a suggestion ought to be referred, rather than to attack it now.

Dr. Stone reads the third recommendation.

DR. BIRNIE: That doesn't cover it. He is talking about the specialists as a whole. I agree with the gentleman from Worcester that you have got to be very careful how this is worded, but a good many of us believe that the real specialist is a man who has training in general medicine, something to back up his specialty. An incident of that was the Symposium on Backache that was published in the BOSTON MEDICAL AND SURGICAL JOURNAL.

DR. EMERSON: I believe a specialist should have of course the broadest possible training, but I think they may have an argument on their side.

DR. BIRNIE: Could the committee on these

resolutions not bring in possibly one more recommendation to be acted on later in the day?

DR. PARKER: This same subject was brought up by Elliott Cutler in an address in Cleveland in which he said that specialties should be a post-graduate rather than a pre-graduate course.

On motion duly seconded it was voted that the committee bring in another resolution along this line sometime later in the session.

DR. PARKER: The subject for discussion today is Medical Registration and Reciprocity between the several New England States. It is a very live subject and one in which we are all vitally interested.

The President introduced the next subject on the program in these words:

In theory, I think we would all agree that it would be ideal to wipe out the political barriers between the States and make the professional requirements for the practice of medicine in New England conform to a common standard acceptable to all of the States. The applicant for the practice of medicine to be required to pass an identical examination in all States, this examination to be prepared through coöperation of the several State Boards or by a representative board chosen from the different States.

This is simple in theory, but practically the problem is very intricate and presents phases which would require much thought and study for their solution.

Any legal changes in the existing methods of examination and registration would necessitate legislative action. This has always been a hazardous procedure when applied to things medical and might present almost insurmountable difficulties. If a course of this sort seemed unwise it is possible that a "gentlemen's agreement" might be arrived at between the Boards of Registration of the several States and by closer coöperation between them practically the same result be brought about.

The disadvantage of the "gentlemen's agreement" would be that it would be workable only in our own immediate profession and would not control the cults as would a law like the Basic Science Law sponsored by the A. M. A. or the Single Standard Law now operative in Massachusetts. This subject is of paramount importance as the present laws are a potential source of hardship to many men whose location makes it necessary for them to practice in adjoining States, or who may wish, for perfectly legitimate reasons, to change their location to another State.

I wonder if those of us who may be called to another State, in which we have no license to practice medicine, to treat patients surgically are not doing so illegally. I think this might be an important question in cases of threatened Malpractice.

Your Executive Committee has chosen representatives from the several States, whom they have deemed particularly qualified, to present the existing conditions in their particular States together with any constructive criticism or suggestions which they may wish to bring to our attention.

It is hoped that there will be a full discussion of this important problem and that some tangible conclusions may be arrived at upon which we may base recommendations to our several State societies.

DR. BIRNIE: I was not able to write out a paper on this subject because I was not sure of my facts. In regard to one point which you just raised, that of the practicing surgeon going to do a surgical operation in another State. A great many State laws are very specific on that point and in some States they give us the right to do it. It is very difficult to find out from books or pamphlets the exact conditions the State Board requires in each State. Massachusetts is an instance. There is no mechanism in the Massachusetts law by means of which reciprocity can take place, and there is no real machinery whereby we can recognize the National Board, but the Board in Massachusetts has received a ruling from the Attorney General, and their action here is to say that they will accept the National Board certificate in lieu of their own examination. There really isn't anything in the law which allows the Board to do that, but we have a ruling that it is legal. I am stating that as a preliminary to the fact that it is rather difficult for me to get the rules from the various Boards. As I understand it, there is mechanism in at least three of the New England States whereby reciprocity can take place. The exceptions to that are Rhode Island and Massachusetts. For instance, starting with Maine, the Maine Board has a right to make reciprocity rules subject to revision by a Supreme Court Judge at any time. New Hampshire has a right to have reciprocity with any other State if they consider that the other State has requirements substantially the same as theirs. Your first two States have reciprocity already. Vermont has reciprocity provided that reciprocity is mutual. Vermont can reciprocate with New Hampshire but Vermont cannot reciprocate with Massachusetts because it is not mutual on the part of Massachusetts. Connecticut allows reciprocity after a man has been in practice five years and if he is going to be a bona fide resident of the State of Connecticut. I have been in practice five years and as I understand it I can go down to Connecticut and register, provided I am going to practice in Connecticut, but the fact that I live in Springfield, four or five miles from the Connecticut line, won't give me the

right. I have got to go to Connecticut to live. That leaves Rhode Island and Massachusetts. Rhode Island, according to its printed report, has no mechanism for reciprocity of any sort, and the Massachusetts law has no question of reciprocity. So if we are trying to work out a scheme for New England, four States already have it in some form, and you would run into difficulty at once if you talked reciprocity with Massachusetts because we have a so-called single standard; thats it, the examinations are the same for the M.D. and for the osteopath. In the eyes of the law in Massachusetts the osteopath is exactly on the same footing as the M.D. He takes the same examination and is allowed to practice as he sees fit. In regard to the medical requirements before the various Boards: Some State Boards require pre-medical education. Now, although the Massachusetts law, for instance, the Rhode Island law and the Maine law do not require a pre-medical education, that doesn't mean anything because practically every medical school in the country today requires pre-medical education. There is no use in putting it in the law but it exists by common consent in the schools. For all States in New England with the exception of Rhode Island the National Board of Medical Examiners covers the subject we are talking about, and of course my advice to any young man would be to take the examinations of the National Board because that is accepted by thirty odd States. It is accepted by the Army and Navy, by the Public Health Service, England, and Scotland and in a number of other States where it is not accepted the Boards are in sympathy but have not yet been able to get authority from the Legislature to adopt it. It is pretty high-grade and it means that a man has got to be a pretty good man to pass it, but that is the answer to the problem as it exists today. It is possible that we could have something in New England, but then again it is questionable. In Massachusetts we would have to go before our Legislature and get certain authority. The doctors in Massachusetts for the last ten or twelve years have been trying to get something out of the Legislature and can't seem to do it. I very much question whether we could get a right for our Board to grant reciprocity in the ordinary sense of the word. We have not been able to get our Board to have the right to classify medical schools or say what medical schools are acceptable. The law in Massachusetts reads that the Board must examine any man who has graduated from a legally chartered medical school which has the right to grant the degree of medicine. We have to examine the men who graduate from the Kansas City Medical School or from Middlesex or from Boston Physicians and Surgeons. I say we because I have been on the Board but I am not at present. The Board has no choice. The man must be examined. That is why the finger of scorn is pointed at us because we will accept such men. The doctors don't want it, but we can't get the Legislature to change it.

Personally, I believe some sort of a gentleman's agreement might be arrived at. I don't believe in a specific statement. In others words, I would dislike to see a law that a registered physician in another State *must* be accepted. I would like to use the words *may be*. To a certain extent in regard to medical matters I believe in State rights. I think there are legal problems in each State which influence this matter and it should be left in the hands of the State Board, but I would have some means whereby with discretion they could grant a right to physicians from other States. It is a question of what you really mean by "reciprocity". Would you have it, for instance, that a graduate of Tufts College Medical School should take the examination and then go and settle anywhere in New England? Do you mean that, or do you want to have him take the examination in Massachusetts and then four or five years from now, if he has to go to Rhode Island or Connecticut, he could be, as you might say, transferred? I think the latter is the proper thing, that there should be some means whereby he could go to the other State. If we could get over the practical difficulty, so that surh an arrangement would exist throughout New England, we would have accomplished something.

Recess until 2:00 P. M.

Dr. Stone, for the Committee brought in a recommendation upon the matter referred to the Committee in regard to specialties, advising that it be inserted in the middle of Recommendation 4.

On motion duly seconded it was voted to adopt the report of the Committee on Medical Education as a whole.

DR. LUCE: I would move that a copy of this resolution be sent to the Secretaries of all the Boards of Registration of the six States, also to the Deans of all the medical schools in our States and to the Presidents of each State Society.

DR. BIRNIE: I would like to add that it also go to the President and Boards of Governors of all the medical schools in the States.

DR. PARKER: Will you make that as a formal motion, Dr. Birnie?

DR. BIRNIE: I move that a copy of this report be sent to the President and Secretary of each State Society of the New England States, also to each President, Board of Governors, and Dean of the New England Medical Schools and to the Secretary of the Board of Registration in each State.

Motion seconded.

DR. ROWLEY: Was this Council formed with

the idea that any conclusions we reached should be brought back to our State Societies in the form of a report for them to act upon as they saw fit? If that is so, I wonder if we ought to go very far in bringing these resolutions which are in the form of recommendations before the Medical Schools; whether our report should not be given to our State Societies first. I don't know what authority was given us when the Council was formed.

DR. PARKER: Are we exceeding our authority in doing this?

DR. BOWERS: I don't see anything in this motion that exceeds the functions of the Council. The Council was created for the purpose of bringing together representatives of the different State Societies in order to discuss matters of common interest and to make such recommendations to the Societies as this body may see fit to adopt. That was the fundamental principle of our organization.

DR. ROWLEY: There was nothing provided for making recommendations except to our respective State Societies?

DR. BOWERS: That is as far as our original purpose appeared in the Constitution and by-laws, but I assume that we are a body of intelligent people and we can extend our information and our feeling as far as we like without doing anything which would be at all improper. I will welcome corrections if there is any different opinion among the members.

DR. BIRNIE: In reply to Dr. Rowley, in the Massachusetts Medical Society this would automatically come up because our Committee is one of our standing committees with a chairman and they will naturally make a committee report at the annual meeting and if their report is accepted, as it probably would be, it would be authorization for anything we did. That is provided for as far as Massachusetts is concerned.

DR. FITCH: I made the motion when we met last spring in Boston and it was voted that the President of each State Society should be a delegate to carry back to the State Society the doings of the New England Medical Council. Possibly that vote has been overlooked. I think each President should be instructed to see that the proceedings get before the House of Delegates in his State Society.

A vote being taken the motion was declared adopted.

Doctors Duncan, Richards and Ricker being absent, the discussion on the regular program was resumed by Dr. Rowley.

DR. ROWLEY: I took it for granted that just an informal discussion of this question was intended, so I did not prepare anything specific along this line. If we are to consider the question of medical education and medical examinations and medical licensure and reciprocity, we first of all ought to have a pretty fair understanding of the conditions that prevail in each State, and it seemed to me if I could say something on what the conditions are in our State you could make comparisons with the conditions as they prevail in the other States. There are several points brought out in Dr. Birnie's remarks of this morning with which we are all directly concerned. Our Connecticut law has for years given the Medical Examining Board the privilege of accepting in lieu of our regular examinations a State license issued by another State provided we are satisfied that the standards of that examination are as high or equivalent to our own examinations. The Connecticut Board never has entered into reciprocal relations with the Examining Board of any other State. In practice, we do, however, something that answers the same purpose and yet meets our ideas of the situation a little bit better. It is difficult, if not impossible, to know exactly whether our standards of examinations have been met in the examination that the applicant may have taken in Massachusetts or Rhode Island or Maine or elsewhere. It is a difficult thing to have any exact knowledge or idea about. We have a general feeling that those State examinations are on a par with ours, but how de wo know; how does anybody know? Inasmuch as the State law gives us permission to accept a license from another State, we do exercise that privilege. We have done it in the last few years, but it is not an automatic proceeding by any means. The mere fact that a man is licensed in some other State,—for the purpose of this discussion some other New England State, and meets our educational requirements as set forth in the law as regards the type of medical school from which he graduated and the kind of pre-medical education he has received, while it is not an automatic proceeding, we let such a man come before the Board and having found out what we can about the record he has made for himself in such State, his standing, and the respect in which he is held by the fellow members of the profession, we then give him an oral examination; and we feel that in that plan there is a great safeguard, and some men do not receive the approval of the Board after such an oral examination, even though they have been allowed to come before us and their credentials are satisfactory. We never have liked the idea of reciprocity which literally means entering into an agreement with the Board of another State to accept all of their licenses by some automatic plan, if that State will agree to accept ours on a similar automatic plan. It seems to me there are some inherent dangers in that proceeding. So, while we never have desired to enter into reciprocal relations with an Examining Board of another State, we do have the doors open for men who are well qualified from other States; and what the State Board of another State may do to those who want to go from Connecticut to that State is a matter that should be the responsi-

bility and duty of the Examining Board in that State to see whether or not that individual is the proper one to be admitted to practice in that State.

We have had in Connecticut no provision whatever for so-called housecleaning in our own professional ranks until lately. A man once obtaining his license in Connecticut could continue unless he were convicted of some felony and imprisoned in consequence. In such case there was provision for cancellation of the license, but for some of the minor things—and not so minor either, but with some of the less serious offences a man once engaged in practice could continue all of his professional life and there was no means of correcting him or of disciplining him. We now have in the Connecticut law that became effective last July a means for calling before the Examining Board a man who has done some things which he should not do that the profession can rightfully frown upon and we are empowered by the law to discipline such physician to whatever extent seems appropriate. We can either admonish him from continuing in such practices or we can recommend the cancellation of his license or the suspension of his license for a period that seems appropriate. I don't know how many other States have that provision in the law, but we feel that is an improvement over what we have had. Another thing that I might speak of is the fact that we *may* accept the State license of another State. We are not required to. It is a matter of discretion entirely with our Board. In the matter of medical schools, our State law requires that an applicant to be admitted to our examinations must be a graduate of a legally organized and reputable medical school and it rests with us to determine whether or not that school is reputable and acceptable; and, another word along that line, we have to file annually with the State Department of Health a list of the approved medical schools, and by "approved" I mean those that meet with our approval; those whose graduates are entitled to admission to our examinations.

The matter of residence was referred to. Until the new law went into effect last July there was nothing in our Connecticut law having to do with the matter of residence except those who were coming to us from other States having been in practice in some other State. With respect to those cases there was a provision that they had to be residents of Connecticut or intended in good faith to reside there. Now, that provision pertains as well to those who are for the most part recent graduates and have come for the written examinations. That provision was put in the law, not by the medical people, but was a direct out-growth of the conditions that were brought to light there when it was found that so many people had gone through the formality required to get a Connecticut license and then had used that only for the purpose of getting reciprocity in some other State and had no intention whatever of residing in Connecticut and those people have gone to distant parts of the country and may some day come back to Connecticut and use those licenses—people who are not as well qualified as we might wish. That all came about, as you know, through the shortcomings of one of the Examining Boards in our State. Conditions there have been very much improved in regard to licensure through the work of the lay board that was formed two years ago—a lay board to examine all applicants from whatever school of practice they may have come, regular schools, homeopathic schools, chiropractic, osteopathic, in what we speak of as the basic sciences, and after receiving the approval of that board they are referred to the board representing their particular school of practice for whatever further examination they think necessary. As a matter of fact, that lay board has functioned so well that it seems to have determined pretty well who is qualified for the practice of medicine. That is shown by the results of our examinations in the last few years, in which the records show that almost without exception the graduates of the regular schools who are referred to us as having passed the requirements of the lay board meet our requirements as well. Our rejection ratio, if we may speak in those terms, has fallen almost to zero. If the graduates from other than the regular schools can meet the requirements held out by that lay board it seems to me it is pretty safe to say they know enough about the fundamentals of medicine to be allowed to practice along whatever line of therapy they may elect.

Perhaps in a further discussion some one may ask some questions on something I can say some more about, but I don't think of anything else now.

DR. PARKER: Have you any ideas whereby we could get together more closely between the several States?

DR. ROWLEY: While the idea of reciprocity among the States is desirable from sentimental grounds, it seems to me from a practical standpoint it is a very difficult thing to work out. Our Board, as I said a moment ago, has always been opposed to that plan, but we try to meet the practical issue by holding our doors open to those who after investigation by us are found to be well qualified. We don't want to shut the doors to any well qualified doctors wherever they may come from, and we allow them to come before the Board and try to measure their real worth. We would like very much to entertain any ideas that can substitute reciprocity for the plan that we are following at present. I don't know how you are going to tell what kind of examinations Massachusetts gives; how they compare with ours year after year. You might compare one set of examination questions given last year with another State's, but how

are they going to be marked? That is the whole problem. We may mark them on an entirely different scale from Massachusetts, for illustration, the same set of questions and the same set of answers. And there is the personnel. Boards change. How are we going to know, if we satisfy ourselves on some plan today,—how are we to know that that will meet with the approval of the Board a year or so after. It seems to me all we can do is about what we are doing now; assume that a man is well qualified if he has met the requirements in one of the other States, but further satisfy ourselves by an oral examination on our own part.

DR. PARKER: The other men who were to speak are not here. Shall we discuss these two papers, or would you prefer to hear from men from other States which haven't been represented in this discussion as yet? We would like to hear from Dr. Partridge or Dr. Kingman of Rhode Island.

DR. PARTRIDGE: Dr. Richards who was to speak is the Secretary of our State Board of Health which is the Examining Board. I had not given the matter any consideration because I thought he would be here and I can't say anything to the point.

DR. KINGMAN: I don't know much about the system. We have no reciprocity. A year ago we had quite a conference about changing the requirements. We desired to have a method similar to that in Connecticut. At present we have an osteopathic board as well as the regular medical board; the chiropractors haven't succeeded in getting their own board as yet. We have no legal means of reciprocity at the present time.

DR. PARKER: Have you any suggestion to make?

DR. KINGMAN: I suppose the finest and best thing is through the National Board of Examiners. That is the thing I should strive for for the coming generations; it doesn't apply to the present generation. I was wondering whether there would be, year in and year out, such difference in examinations as to really be a question,—whether the average of the examination papers and the Examining Board varies from year to year enough to make the point. I feel somewhat as Dr. Rowley says his Board does, that an absolute mutual reciprocity would not be a good thing, that there might be a little too much chance of a man just escaping out of one State and by reciprocity getting into another before he is called to account in the State in which he has his license. It seems to me each State should have some power of selection as to whom they admit to the practice of medicine.

DR. PARKER: I would like to hear from Maine. Dr. Bryant, have you something to offer?

DR. BRYANT: I am sorry that Dr. Leighton, Secretary of our Examining Board, is not here. He has a decided opinion on many things as regards licensure. I know very little about the licensing board. I know that we have reciprocity with several States. We have gone the limit in the State laws in having three licensing boards—one regular, one for osteopaths and one for chiropractors. So far, we have kept the osteopaths from practicing surgery and obstetries. Our hope is to some time get together with the various cults and get a basic examining board, and if they pass that, then go to their own boards. If they have the education up to that point, we can turn them loose and they can practice anything they wish to. I think that is the sentiment.

DR. PARKER: I would like to hear from New Hampshire. Dr. Fitch, have you anything; have you any suggestions to make or constructive criticism?

DR. FITCH: Nothing of any value.

DR. WILKINS: When Dr. Birnie was telling about the regulations of the New Hampshire Licensing Board, he did not mention the fact that the osteopaths are examined by the same board in the State of New Hampshire and are obliged to pass the same examination, and then they are allowed to practice whatever therapy they desire. The chiropractors have a separate board; also the optometrists and the chiropodists.

DR. LUCE: I don't know that I have anything constructive to offer. I am somewhat in sympathy with this. I wish we could get together in some uniform way in the six States, but I am not at all in sympathy with reciprocity as we practice it in New Hampshire.

(Reviews local cases—Portsmouth.)

I would like to ask about revoking licenses; I would like to know how far Dr. Rowley's Board can go in the absence of criminal conditions in revoking licenses?

DR. ROWLEY: It might be interesting to read that part of the statute. (Reads.) This law went into effect the first of July of this year and within the last week or two there have been referred to me the complete copies of the hearings in the case of five doctors practicing in Connecticut whose liquor permits or permits to prescribe liquor were under investigation. After the hearings they were convicted of illegal use of those permits and the permits recalled. Under the provisions of this law that is a matter that can come before our Board and our Board is permitted to exercise some disciplinary measures, whatever we deem to be appropriate in those cases. The Board has not met to take up these particular cases.

DR. BIRNIE: Massachusetts has practically all those provisions except advertising. In this State they come before the Board of Registration if they have had their liquor permits taken away. We have had several cases. We can suspend a man's license if he doesn't record births; we have had to do that several times. A man

is supposed to record births and the Board has permission to give him a vacation if he hasn't done so and let him write up his certificates.

DR. BRYANT: I think in Maine it is only a conviction in court for misdemeanor; it must be a court conviction.

DR. STONE: I would like to ask a question. I thought there was a provision in a bill introduced into the legislature to permit our State Board to accept the National Board examinations. What was voted on that bill?

DR. BOWERS: It was passed.

DR. BIRNIE: Is that the law?

DR. BOWERS: Yes. The Attorney General interpreted the law.

DR. STONE: It seems to me that our problem in this State is to cling fast to that which we hold and in addition try to get permissive legislation along the same lines. I think we should try to get permissive legislation which would give our Board the power to register those registered in other States in addition to the permission it now gives to accept the National Board examinations.

DR. BOWERS: I want to compliment Connecticut for having cleaned up one of the worst situations in the whole United States. You have made a start and done a good deal. As an illustration, I might refer to one of the men that you have disciplined recently, a man by the name of Yokleman. Yokleman applied to the Board of Registration in Massachusetts, and that was before the law obliged us to accept people who were graduates from medical schools only, and it was found that a person was appearing on that application who was not Yokleman and he was cousin of a prominent specialist in the State of Massachusetts. That man lived in Poughkeepsie, N. Y., and apparently had sold his intelligence—of course he was a very intelligent fellow—to those people who wanted to pass the examinations but were unable to meet the requirements. When that was discovered a policeman was sent for and he evidently suspected something and there was a vacancy in that seat before the policeman got there. So Yokleman did not succeed in even taking his examination by proxy in the State of Massachusetts. He was a very colorful individual. On his application he claimed that he had graduated from a Russian school. In looking up his birth according to his record he would have had to graduate from that school when he was eight years old. So his whole history was as bad as it could possibly be; at that time anybody could be registered in Connecticut, and after being registered he got into trouble because he was a particularly bad actor. So I think we may feel that Connecticut has accomplished a great deal in the progress that has been made with reference to clearing up all this situation.

When you come to consider reciprocity, several opinions have been expressed as to the legality of this procedure. There may be a bombshell in reciprocity because some good legal opinions have been reported to the effect that reciprocity is unconstitutional, based on the recognized principle of law that while a State may confer executive powers on the officials of another State, no State can delegate judicial powers to any other organization than that which is created within its own State. That is a principle of law that has been upheld by the Supreme Court, I have been told. Now, this particular matter of reciprocity, so far as its legality is concerned, unless passed upon very recently by the higher courts, has never been decided and the reason of course is that there would seldom be any occasion to bring that question up for judicial interpretation. It would be a very unusual circumstance that would lead anybody to raise the question of the legality of a physician's licensure through reciprocity, so, as I said a moment ago, in all probability that never has been passed upon by the courts. But there are provisions in every law, providing the Boards feel so disposed, which may be applied, in my opinion, to meet this thing in a way which would be practically acceptable, assuming that the Boards will all come to an understanding. Now, it is true that every State Board is under obligation to meet certain legal requirements in the examinations, but no State requires a Board to be arbitrary in the application of the provisions of the law. We must recognize that examinations are simply for a purpose and that is to determine the fitness of an individual to practice medicine in a State and that is the end to be desired and to be sought; and we must also recognize that the examinations are not applicable to certain types of individuals; that is, the same examination which you would give to a recent graduate would be a very unreasonable examination to require of a person who had been in practice 25 or 30 or 40 years, because the technical examinations are all designed for the recent graduates, to determine whether they have had medical education according to the standards of the present day, and we all know that a practitioner of many years' standing could not meet the technical requirements of an examination designed to test the fitness of a recent graduate. Now, it seems to me, that every Board can meet every requirement of law if it will have special examinations for the different classes of people who come before it; that is a technical examination for the recent graduate and a practical examination for the older man, with the record which the older man can bring of his standing in certain communities and the testimony of his associates, which is very much more valuable than technical questions. It seems to me that if all the Boards would come together on that basis, and say we will have the technical examination especially for the younger men we will have a working gentleman's agree-

ment. We will have to have separate examinations for the older men, because when you come to examine a group of men together and you mix the older practitioners with the young men it is impossible for a Board in fairness to properly pass upon the answers as given by the different classes. This would involve a little more work but I think if the Boards would adopt this simple method it would work out very well. It is a plan that has been adopted by some boards, but after a while the boards become, as many State boards do, a little addicted to red tape, do not want to accommodate themselves to the requirements of different types of examinations, and after a time they rebel because they are imperfectly paid; members of boards spend a great deal of time for which they receive no adequate remuneration, and they feel that the State is requiring too much of them. If the State can be led to deal with the examiners in a more liberal way and the examiners are willing to be self-sacrificing I think that a plan can be made that will work perfectly well. It is a gentleman's agreement that might be observed in all States.

The New England Examination Boards have an association and they have discussed these problems time and time again, and they have on several occasions tried to have an examination common to all the Boards. You can see the difficulty in that. The Boards do not meet at the same time and if questions are used at one time in one Board they may very easily get into circulation, and another objection is the matter of marking. As one gentleman has said today, the different standards in vogue in the different States are so varied that there would be no uniformity in the marking, and one State would object to a man and another accept him on the same examinations. The National Board is a wonderful thing and has accomplished a great deal and it will grow in its applicability to the situation. Thirty-seven States at present accept the examinations of the National Board. Whether that will ever come up for judicial interpretation is an open question. This, like the question of reciprocity, is a serious problem. The fact that comparatively few men take the National Board examination leaves a considerable number to be considered. Since I have been off the State Board it has been my privilege to act as one of the examiners for the National Board. An interesting thing in that connection is that I was very agreeably surprised to find that a considerable number of them intend to go into general practice and are not planning for specialties.

The reason that Massachusetts has to take in the graduates of osteopathic colleges is because in the original litigation against the practice of osteopathy the Supreme Court rendered a decision that the practice of osteopathy is the practice of medicine, so that when the law defined the educational qualifications as applying to anybody who had graduated from a medical school giving a four years' course, osteopathy being the practice of medicine, of course that made the applicant in osteopathy entitled to the examinations, the same as those from any other medical school.

I am satisfied that if the different States would adopt some such method as has been suggested all this difficulty about reciprocity would be eliminated.

DR. PARKER: Dr. Wheeler, would you say something on the subject?

DR. WHEELER: It is a very interesting discussion, but I know practically nothing about it. I have learned a good deal today. Anything that I might say would only be in line with the ideas already brought out.

DR. ROWLEY: It is a source of a good deal of satisfaction to me to realize that we have in Connecticut a working plan that is almost identical with what Dr. Bowers feels to be his ideal. It is just exactly what we are doing now. Those men who have been in practice come before the Board and are asked some practical questions along lines in which they are obviously especially fitted. If surgeons they are asked surgical questions, etc.

DR. PARKER: We have had a very good expression from the men who have spoken of the conditions existing in their respective States, and I know I have learned a lot from it, and I think there are things that have been presented that it would be well to adopt in some of the other States. Do you wish to take any action today on this matter? Do you wish to put forward any recommendations that we could take back to our States, or do you prefer to appoint a committee to go over this at length and report at a later date?

DR. BIRNIE: I think the latter suggestion is a good one, that a committee be appointed. There is an association of Medical Boards and I think it would be only right and courteous to get in touch with them before we bring out something which might be called constructive.

In some of this discussion we have been talking about the same thing under a different name. We talked about a fundamental examination board and then special examinations and examinations along special lines. In Massachusetts and New Hampshire there is a fundamental examining board instead of a special board for the different schools and the only thing we have to look out for is to see that the chiropractor and others come before the Examination Board. I think the appointment of a committee or selection of a committee to work out something along the lines of Dr. Bowers' suggestion is the simplest thing that would be perfectly fair. I think a gentlemen's agreement is very much better than a general law.

Upon motion duly seconded it was voted that the chair appoint a committee of six representing

the New England States to consider this matter and report at a later meeting.

DR. PARKER: I think the Executive Committee would like at this time to have some suggestions as to subjects for discussion at the next meeting, which will be sometime in the spring.

DR. FITCH: The New Hampshire Medical Society is working on the problem of insurance to some extent and I think it would be helpful to have this body consider the subject of insurance.

DR. ROWLEY: It has fallen to my lot to be chairman of the legislative committee of our State Medical Society for some few years and one thing I would like to have discussed and cleared up before this body if we can do it is how to get enough interest aroused in the members of the profession to have them go and assert themselves before the legislature. If you are going to have a legislative hearing, some representation from the medical society should appear. You haven't got to have 100%, but if some legislative matter is being heard and there happens to be a large attendance from another group of practitioners and they are represented 50 or 60 per cent. and only one or two in the regular medical society, it places the medical society at a disadvantage. Their absence is interpreted to mean that they are not interested in the proposed legislation. That is ground for serious thought.

DR. STONE: How about going further back and having a meeting on the education of the public on medical matters? I agree with Dr. Rowley that we must have representation at committee hearings. We are swamped 1000 to 1 on a count of noses, but we must also go much farther back to popular education.

DR. BALCH: Could that be accomplished by having various medical society representatives from different parts of the State report that each represented so many constituents?

DR. STONE: You can't get them to attend.

DR. PARKER: Medical education of the public is a very good subject and embraces the matter of medical advertising, propaganda, etc. I think it would be something that would be very interesting and would be of some use to us.

I know I voice the sentiment of this body in thanking Dr. Rowley for coming up here and giving us the valuable ideas that he has in regard to registration and also telling us about the things they are doing in Connecticut. We appreciate his presence here very much.

On motion duly seconded it was voted to adjourn.

Adjourned at 3:30 P. M.

SEASONAL PREVALENCE OF TULARAEMIA

Seasonal incidence of cases of tularaemia, according to the United States Public Health Service, is due to the seasonal variation of three sources of infection, tick bite, fly bite and the dressing of wild rabbits, but owing to the overlapping of these influences, cases have occurred in the Unite States in every month of the year. The great reservoir of infection and the greatest source of human infection from tularaemia is the wild rabbits, jack, cottontail and snowshoe varieties, but owing to the agencies of blood sucking insects common to rabbits and man, we find cases resulting from tick bite and fly bite.

Of the rabbits offered for sale in the Washington, D. C. market in the winters of 1923, 1924, and 1925, Dr. Edward Francis of the Public Health Service examined the livers of 1,000 and found 9, or slightly less than 1 per cent, infected with tularaemia. The liver and spleen of an infected rabbit are studded over the surface with small spots varying in size from that of a pinpoint to one-sixteenth inch in diameter. Of 22 cases of tularaemia in Washington, 17 of the patients had dressed wild rabbits bought or sold in the market, 4 had dressed rabbits shot nearby, and one had dressed a rabbit which he had killed with a club.

Four hundred and twenty cases of tularaemia have been reported, of which 17 have died. This places the mortality at about 4 per cent. These figures enbrace only the cases which have been reported to the Public Health Service, but considering the newness of the disease, they probably represent only a portion of the actual number of cases and deaths.

Cases have now been reported from Japan, from the District of Columbia and from 37 States. The nine northeastern States, being the only significant portion of the United States in which cases have not been recognized.

As a rule when the infection has come from a rabbit some injury has been inflicted on the hand while dressing the rabbit, although a manifest injury is not necessary for infection to occur. Usually an ulcer develops at the site of infection accompanied by enlargement of the lymph glands which drain the ulcer. Fever is always present and continues for two or three weeks. The site of infection from tularaemia may be located on any part of the body other than the skin of the hands, if due to tick bite or fly bite. The diagnosis of tularaemia is confirmed by a blood test. One attack confers immunity in man. Rest in bed is the most important treatment. The enlarged lymph glands should be opened only after pus has definitely formed.

The infection has never been found in nature in domesticated rabbits.

No preventive vaccine or curative serum has yet been perfected nor has any special drug been found effective against tularaemia.

Rabbit meat thoroughly cooked is harmless for food. and it has been found that a temperature of 56° Centigrade, or 133° Fahrenheit kills the germ of tularaemia. The ordinary disinfectants are effective. Rubber gloves should be worn by those who dress wild rabbits. Immune persons should be employed to dress them where possible. In fected rabbits, kept frozen for thirty days, have been found to be free from infection. Market inspection of rabbits is impracticable, because only about 10 per cent. of the rabbits found in the market still have the liver in place.

Beware of the wild rabbit which the dog or cat has caught, or which was killed with a club,—it is probably a sick rabbit.

Case Records of the Massachusetts General Hospital

ANTE-MORTEM AND POST-MORTEM RECORDS AS USED IN WEEKLY CLINICO-PATHOLOGICAL EXERCISES

EDITED BY R. C. CABOT, M.D.
F. M. PAINTER, A.B., ASSISTANT EDITOR

CASE 13591

FEVER OF UNKNOWN CAUSE

MEDICAL DEPARTMENT

An American architect thirty-nine years old was sent to the hospital November 24 by a physician, with a diagnosis of typhoid.

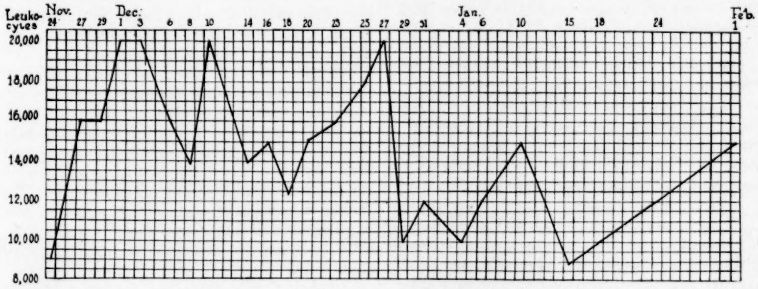
Eleven days before admission after riding horseback he suddenly had a chill and headache. At the onset he had a little cough. For six days he had been in bed. He felt well except for weakness.

His past history is unimportant except that two years before admission after falling from a horse and running for a train he had an attack of dyspnea. Since that time he had been able to ride horseback, climb stairs, etc., without trouble with a little care.

Clinical examination showed a well nourished man with some cyanosis of the lips which he said was usual with him. The apex impulse of the heart was not seen or felt. The left border of dullness was in the fifth space 4½ inches from midsternum. There was no enlargement to the right. The action was regular, somewhat rapid. Over the sternum at the junction of the third and fourth ribs the first sound was entirely replaced by a very loud, harsh blowing systolic murmur. The second sound was not heard at the apex and was replaced elsewhere by a loud blowing diastolic murmur heard with greatest intensity over the same area of the sternum as the systolic murmur. The pulmonic second sound was audible, the aortic second replaced by a murmur. The pulses were equal, synchronous, of good volume and tension, bounding and of Corrigan type. The artery walls were not felt. There was a waving throbbing of the veins of the neck. The lungs, abdomen, extremities, pupils and reflexes were normal.

The urine was negative at the first five examinations. Beginning January 7 there were increasing amounts of albumin. March 3 to 15 the urine was brown or red, afterwards high colored. The sediment was negative at eight examinations previous to January 21; afterwards all but three of eighteen specimens showed red blood cells, increasing up to March 21, then becoming fewer. The leukocyte counts are shown in the chart. Three blood cultures were taken. A Wassermann was positive. Nine Widals were negative.

The patient ran an irregular temperature during the four months he was in the hospital, ranging from 96.8° to 104°. After March 5 it was not above 101°, after March 12 not above



Leukocyte counts.

normal; but to the end it continued to show waves of higher and lower range. The pulse was 78 to 137, following somewhat the general waves of variation of the temperature. The respirations were from 15 (with morphia) to 35, with a terminal increase to 47.

December 2 there was a definite high pitched distant continuous hum with systolic accentuation over the pulmonic area, entirely different in quality from the to-and-fro murmur. The patient grew weaker and more dull. He complained of chilly sensations daily at about one p.m. December 14 he vomited his dinner. The heart sounds again seemed to be changing. The murmurs were not so loud as at admission. December 22 the right border of the heart seemed to be coming in. The patient looked weaker and paler, however, and had slight tremor, which became more marked. January 11 he began to sit up in a chair on the porch for fifteen minutes a day and gained some strength.

January 25 after getting up he had a severe fit of coughing and a chill. There were a few crackles in the lower two-thirds of the lungs. From this point he slowly lost ground, except for one brief period of improvement early in

February. February 11 there was a leathery friction rub over the upper right front of the chest. He again became weaker and showed marked tremor. The urinary sediment, which had been negative at ten of eleven examinations up to February 16, now began to show red blood cells and granular and cellular casts constantly, and after the first of March the urine was brown, red or high colored. Every day or so he had a chill and sweat. After March 4 these stopped. March 15 he was vomiting almost everything. This continued. March 19 he was mildly delirious and had crackles in the lower two-thirds of the lungs. March 23 a to-and-fro friction rub appeared. March 24 he died.

Discussion

BY RICHARD C. CABOT, M.D.

NOTES ON THE HISTORY

This case is quite ancient history,—1910.

I think we should agree that this is not at all a typical history for typhoid.

I do not see that we can draw conclusions from this past history. I think any of us who had fallen from a horse and run for a train might have been short of breath from the combination of emotion and exercise. It seems to me we have to say that here is a man with a negative past history who has some sort of infection, and that is all we know yet.

NOTES ON THE PHYSICAL EXAMINATION

This cyanosis of the lips is a point worth spending a little time over. A good many people have it all the time. We do not pay any attention to it if we see that the individual is weather-beaten or if other circumstances about him make us disregard it. I think if we went literally by the color which we see we should put down "cyanosis" much oftener than we do. I think what we do is to look at the color of the lips and if we think he has a known lesion as cause for cyanosis we put it down as cyanosis. If we do not think he has a cause for the bluish color we do not put it down at all.

We get later a reflection of our interest in 1910 in observing vascular waves in the neck. We thought we were very scientific and up-to-date when we noticed that there were venous or arterial waves in the neck. This is about the time we began to hear about Mackenzie and polygraphic records. I do not think anybody today pays much attention to this, because we get the same sort of information in better ways.

The important fact in the leukocyte counts is that for a good while they are above 14,000. 20,000 is the highest point, reached four times; and as in other cases like this there were sudden rises and falls. The later part of course tends to be lower. I think we can certainly say that cannot be unimportant. In all probability it points to infection.

As he is having fever we do not pay much attention to the positive Wassermann, that is so common in febrile patients.

I wonder if we keep anybody four months in a hospital nowadays. This case sounds like old times; he would have been transferred elsewhere today.

They kept a careful chart for many weeks, and except that it is lower at the end, and that it is usually 101° to 102°, I do not think there is anything to note in it.

Apropos of his pallor, is anything said about hemoglobin or red count? They ought to have done that.

Miss Painter: At entrance the hemoglobin was ninety, the reds not remarkable. On February 10 the hemoglobin was eighty.

Dr. Cabot: Up to that time, then, he does not seem to have developed any anemia.

DIFFERENTIAL DIAGNOSIS

The striking thing here is that he does not complain of pain. He is four months in the hospital, has a fever and finally dies, yet as we get it he does not complain of much of anything. With the fever and the heart murmurs I do not see that we can doubt that the main diagnosis is subacute bacterial endocarditis. We certainly have no reason to think of tuberculosis or of typhoid. It certainly must be some type of sepsis. We have good reasons to locate that sepsis on the heart valves, and no reason that I see to locate it anywhere else. It is true we have first a pleural and later a pericardial friction rub. But those are very natural metastatic manifestations with the heart as distributing center.

I think the kidneys of interest. It has been shown many times that we get acute or subacute glomerulonephritis in cases of this type, and I think that is as likely as anything to be found there. It is possible that he had infarcts. Kidney infarcts will give some of those signs in the urine, but I think on the whole that the picture is more like nephritis than it is like infarct. I think on the whole I should say subacute glomerulonephritis.

We have nothing to make us suspect the gastro-intestinal tract or the nervous system. The lesions ought to be cardiac, very possibly pericardial, and pulmonary and renal. The aortic valve I should say was certainly involved. I think this process is certainly attached to the aortic valve, and in the majority of cases in which such vegetative endocarditis is attached to the aortic valve we find an old fibrocalcareous process on this valve and some lesion on other valves also.

We have still the problem of that continuous hum in the pulmonary area with the systolic interpretation. I do not know what to say about that. We have found such hums a number of times with a patent ductus arteriosus, a congenital lesion. That is not at all likely to be present here. Of course it is conceivable that with

this acute process on the aortic valve he had an acute aortitis, the so-called mycotic aneurysm. Whether that could involve the pulmonary artery in such a way as to give us this continuous hum I do not know. I have never known that physical sign in connection with this lesion. But this is just the sort of case in which mycotic aneurysm does occur.

I do not see any reason to suppose the mitral valve involved from the physical signs. Often these cases do involve more valves than we can recognize during life to be affected, so that we are perfectly prepared to find that the disease is on other valves also. But I do not see that we have any evidence to point to any except the aortic.

Most of these cases show some hypertrophy, not very much. So although our physical signs do not back it up I should suppose that would be present.

Against this diagnosis one might say that there has never been any evidence of organisms in the blood stream in spite of three blood cultures. But that does not seem to me of importance. It is very easy to miss these organisms unless they are in enormous numbers. We could not say that we have no embolic manifestations, because the friction sounds in the pleura and myocardium, if correctly recorded, would suggest embolic lesions there, and I suppose the nephritis, if it is present, could be considered as a manifestation of embolism.

BACTERIOLOGICAL REPORT

Blood culture January 30: A slight growth of atypical streptococci morphologically similar to those obtained in Necropsy 2393, a case of ulcerative endocarditis, and also in rheumatic cases. (The descriptions of the organism are consistent with streptococcus viridans.)

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Ulcerative endocarditis, streptococcus.
Aortic and mitral disease.
Congenital heart, patent ductus?
Acute pericarditis.
Left pleurisy.
Edema of lungs.
Chronic passive congestion.
Renal infarcts.

DR. RICHARD C. CABOT'S DIAGNOSIS

Subacute bacterial endocarditis of the aortic valve.
Mitral disease?
Micotic aneurysm?
Hypertrophy and dilatation of the heart.
Subacute glomerulonephritis.
Infarcts.

ANATOMIC DIAGNOSES

1. *Primary fatal lesions.*

Chronic endocarditis of the aortic valve.
Ulcerative endocarditis of the tricuspid and aortic valves.
Serofibrinous pericarditis.

2. *Secondary or terminal lesions.*

Hypertrophy and dilatation of the heart.
Chronic passive congestion.
Septicemia.
Soft hyperplastic spleen.
Subacute glomerulonephritis, capsular form.
Diphtheritic enteritis, lower end of ileum.
Thrombosis of a small branch of the right pulmonary artery.
Small persistent portion of thymus gland.

DR. TRACY B. MALLORY: Bacterial endocarditis was found, rather unusual in the location of the vegetative masses. The mitral valve was entirely negative. The aortic showed an old fibrous process deforming two of the cusps, and a fresh vegetation. The tricuspid valve showed a relatively enormous vegetation, the measurements given being 3.5 by 2.5 by 0.4 centimeters. This hung down through the valve into the cavity of the right ventricle. There was also very marked ulceration of the valve producing a big hole in the posterior cusp. Just posterior to this the ulcerative process had involved the interventricular septum and had penetrated through from the right to the left ventricle, without, however, involving the bundle of His.

The other findings were almost exactly as predicted. There was an acute pericarditis, hypertrophy of the heart, chronic passive congestion of the spleen and liver, and a subacute glomerulonephritis, rather marked in degree and rather more widely distributed than is particularly common in these cases. Usually the lesions are fairly obviously embolic. Although not all the glomeruli were involved in this case a very considerable portion of them was, and the lesion was of the so-called capsular rather than of the intracapillary type, which is also a little against an embolic lesion, although not entirely ruling it out.

The culture findings from the heart blood and spleen and the periardial fluid were in each case a mixture of staphylococcus aureus and streptococci. This was before the days of accurate differentiation of streptococci with hemolytic tests, so we do not know with certainty which organism it was. The perforation of the valves in the heart and the interventricular septum would go better with the staphylococcus as the more important etiologic agent in the case.

DR. CABOT: That continuous hum with the systolic accentuation I suppose must have been due to that hole through the interventricular septum.

DR. MALLORY: I think so.

DR. CABOT: I did not think of the possibility of that at all.

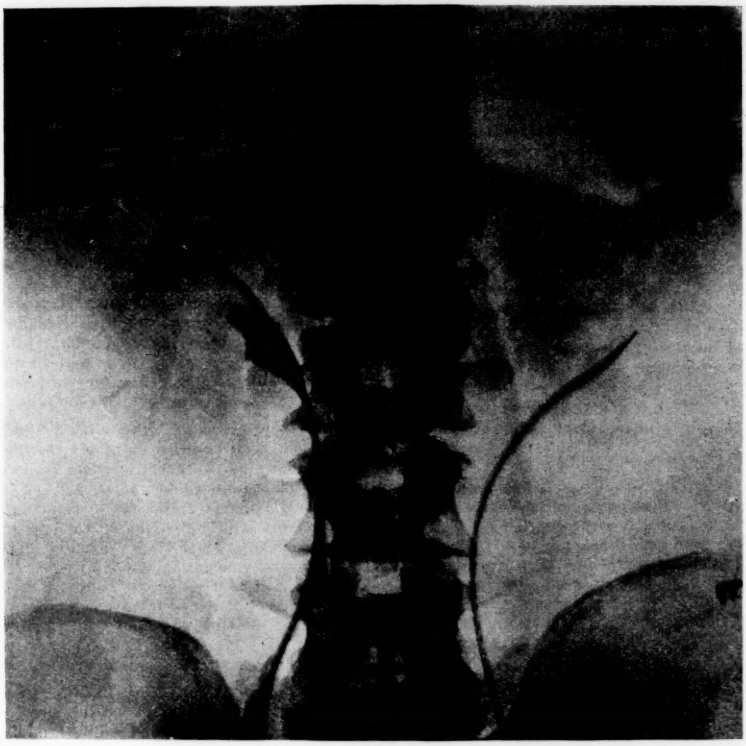
CASE 13592

UROLOGICAL DEPARTMENT

First admission. An Irish-American fifty-eight years old, formerly a telephone lineman, entered the hospital May 26 complaining of hematuria and a mass in the right upper quadrant.

For two years he had had intermittent attacks of painless hematuria lasting a few days and clearing up suddenly. A year before admission he began to have pain in the right side with these attacks, a mass in the right upper quadrant, some frequency and burning and slight urgency. The entire urinary flow was blood tinged. In February, five months before admission, he had a sudden attack of severe cramping knife-like pain localized in the mass in the right upper quadrant, not radiating, severe enough to make him go to bed. The mass began to increase rapidly in size and to become quite tender. The frequency, urgency and hematuria increased.

At cystoscopy in the Consultation Clinic February 20 the bladder mucous membrane was pale but otherwise normal. The ureters were normal. Both sides were catheterized without obstruction. The urine from the left was clear, that from the right slightly cloudy. The renal function appearance time from the left kidney was three and a half minutes, with a total function of 12 per cent. in fifteen minutes. The right kidney did not drain. On X-ray examination the outline of the left kidney was fairly well seen. The lower pole overlay the upper border of the crest of the ilium. The opaque catheter appeared to be well within the kidney pelvis. The outline of the right kidney was not visualized. The entire right flank seemed to be increased in density. About an inch below the



Pyelogram taken five months before admission. The entire right flank is increased in density. About an inch below the tip of the last rib is a linear shadow of increased density which is present in all films. Following injection of the opaque media the right kidney did not fill completely; the pelvis appears deformed as if by pressure. Leading from the tip of the catheter is a small amount of opaque mixture which apparently got into the kidney.

tip of the last rib was a linear shadow of increased density which was present in all films. Following injection of the opaque media the right kidney did not fill completely and the pelvis appeared deformed as if by pressure. Leading from the tip of the catheter was a small amount of opaque mixture which apparently got into the kidney. Following removal of the opaque catheter on the right deformity of the pelvis was still present. The major and minor calices were not visible. There was considerable reflux of the media back into the bladder. The blood vessels of the pelvis showed marked calcification. Several small shadows of increased density probably represented phleboliths. Films of the skull, chest and long bones showed no definite evidence of abnormality. The lungs showed very slight increase in the root shadows on both sides, and a few small calcified glands at each hilus. There was very marked calcification of the femoral blood vessels and their branches.

Following the cystoscopy the urine became dirty and dark brown. The tumor in the side rapidly diminished in size and became nonpainful. Ten days before admission to the wards the patient again had a severe attack of pain and the tumor again swelled to two or three times its ordinary size. Three days before admission the tumor again began to subside and the urine became dark brown and not frankly bloody. Since that time the urine had been filled with brownish to black-red sediment. Frequency up to fifteen times by day and once or twice at night with some urgency and burning had been increasing during the past few months. During the past year he had had loss of appetite and general weakness and had lost forty or fifty pounds.

The family history is irrelevant.

The patient had always been healthy until the present illness. At sixteen he had gonorrhea, which was treated for two or three weeks and gave no further trouble. His bowels had always been constipated, requiring cathartics every night. Thirty years before admission he had malaria. The last attack was twenty-five years ago. Two years before admission he fell from a telephone pole, striking on his right side. He had no trouble at the time.

Clinical examination showed a man with pale, sallow, thin looking skin showing evidence of loss of a great deal of weight. Mucous membranes pale. Teeth all gone. Chest barrel shaped and hyperresonant. Breath sounds emphysematous. Heart not enlarged. A soft blowing systolic murmur all over the precordia, most marked at apex. Sounds rather distant and of poor quality. Radial and brachial arteries palpable, brachials tortuous. In the right upper quadrant a firm nodular movable mass apparently connected with the right kidney was easily palpated, descending with respiration. No attachment to the liver was made out. There was slight tenderness in the lower pole. A sense of mass made out in the right costovertebral region. A definite mass with tenderness on palpation was made out laterally in the loin at about the level of the outer half of the twelfth rib. Extremities, pupils and reflexes normal.

Amount of urine 70 to 73 ounces when recorded, specific gravity 1.020, cloudy, a slight trace of albumin, 4 to 5 leucocytes and 6 to 8 red cells per high power field, many bacteria. Blood not recorded. Wassermann negative. Non-protein nitrogen 35 milligrams. Uric acid 2.9 milligrams. Renal function: appearance time six minutes; in two hours 60 per cent.

May 29 the patient was discharged to attend to some business matters and return for operation.

Second admission, May 31, two days later.

Another X-ray examination showed no definite evidence of abnormality in the humeri, skull or chest. The blood vessels showed a high degree of calcification.

June 2 operation was done, followed by transfusion of 500 cubic centimeters of blood. The patient made a good convalescence. The day of his discharge, June 26, the wound was solid except for a sinus a few centimeters long discharging a small amount of pus. He was feeling well and walking short distances without fatigue.

He was seen at the Tumor Clinic August 19. He had gained thirty pounds and was having no cough, hematuria, pain or tenderness. Some motions pulled on the scar. Physical and X-ray examinations were negative. October 28 he looked in perfect conditon. November 2 he was given prophylactic X-ray treatment without reaction. He returned at intervals of three to six months for the next two years. He continued to gain weight and to look and feel perfectly well. All examinations were negative.

Discussion

BY GEORGE GILBERT SMITH, M.D.

One would be pretty well able to make a shrewd guess as to the diagnosis from the facts given in the first two sentences. Tumor of the kidney of course would be the most obvious guess, although an enlarged kidney due to stone, the stone being accompanied by hematuria, might present this picture. Also one might suspect a carcinoma of the bladder which involved the right ureteral orifice, with backing up in the right kidney, which would cause enlargement of the kidney. But the best guess, because of course it proved to be the correct one, was tumor. That diagnosis would occur to any urologist on hearing these facts.

Ordinarily with a tumor of the kidney the characteristic symptom is painless hematuria.

In other words, the blood coming down into the bladder does not irritate the bladder unless the bladder becomes so filled with clot that the patient is unable to void. In this case the frequency of urination, the pain, burning and urgency, are strongly suggestive either of something in the bladder which might have involved the kidney secondarily, or of infection supervening on some other condition.

I regard an output of fifteen per cent. in the first fifteen minutes after the dye has appeared as the normal function of a kidney. It is possible that there was some leakage around the catheter, so that twelve per cent. is not an important deviation from normal.

This linear shadow of increased density might have been calcification in a tumor of the kidney.

This is the X-ray plate taken before the injection. Here is the linear shadow spoken of, a rather delicate shadow which since it appeared constantly may well have been due to calcification. One cannot make out very well the outline of the kidney. The whole kidney is rather dull. Here the outline of the kidney is rather low.

Here is the right pyelogram with the injection mass cut off pretty abruptly. A little goes into the upper calix, but there is what is called a filling defect in all the rest of the pelvis, showing that the pelvis is occupied by something else. That something else may be blood clot, but of course with the other symptoms is strongly suggestive of tumor of the kidney which has grown into the pelvis and filled up the calices. Reflux of the media simply means that there was not room for it in the bladder and it flowed back.

Of course "the blood vessels of the pelvis" refers to the bony pelvis, not the kidney pelvis.

The suggestion of the dark brown urine to my mind is that the passage of the catheter had freed the obstruction to the ureter, perhaps cleared away blood clots from it, and allowed the kidney to drain better.

The change in the tumor is a rather unusual finding in hypernephroma, because usually the passage of the catheter causes no change in the size of the tumor. But in this case we are forced to believe from the pyelogram that this mass is due to a tumor of the kidney and that the extra pain in the kidney and the extra swelling were due to a hydrophrosis added to the tumor, very probably with some infection.

I doubt if this statement about the swelling of the tumor is true, because I do not see what there was to swell up to that degree. It probably was a little larger; it could not swell to two or three times the size of the tumor we saw in the X-ray.

Here is a man who seemed to be in a pretty bad way; we made the diagnosis of hypernephroma of the kidney. In certain cases one can make the diagnosis between carcinoma of the kidney of the epithelial type which originates in the pelvis usually, and hypernephroma which originates in the cortex of the kidney, the distinction being based a good deal on the pyelogram and on the fact that in epithelial cancers there is a good deal more destruction of pelvic space than the size of the tumor would account for. An epithelial tumor in the kidney pelvis will fill up the pelvis pretty quickly, even before it makes much of a tumor of the kidney, whereas a hypernephroma will often be a very large tumor before it encroaches on the pelvic spaces. These distinctions do not always hold, but it is possible sometimes to distinguish before operation between these two types of tumor.

I think that there is no relation beween the blow and this tumor of the kidney, but it is an interesting observation. We do not know what causes tumor of the kidney. A number of men believe that these hypernephromata are due to inclusion of cells of the adrenal type in the newly forming kidney, that they rest until the patient reaches adult years and then begin to grow.

This is the sort of heart which we might perfectly well expect with a man who had lost a lot of weight and a good deal of blood. His blood is not recorded, but undoubtedly he had a marked anemia.

Of course all these masses are really the same mass but approached from a different angle.

This is a very good renal function and undoubtedly was provided by the left kidney, because I do not believe his right kidney was doing much work. It was not when the ureter was catheterized.

Hypernephroma of the kidney is a tumor likely to have widespread metastases. These are likely to show up in the supraclavicular glands, and are, as we know, very often found in the long bones. The theory has been advanced that the reason why these deposits of tumor are found near the ends of the shafts in long bones is because at the junction of the red marrow with the cancellation at the end of the bone the blood vessels change from wide channels to narrow channels, and these small emboli of tumor cells will suddenly become held up by the change in caliber of the blood channel and will start to grow in that situation. But this man showed no evidence of hypernephroma anywhere outside the kidney.

As I remember this case he had an incision which was described by and advocated by Dr. Hugh Cabot at a meeting of the Genito-Urinary Surgeons about three years ago. The incision begins at the ensiform, extends to the umbilicus, then directly across the flank. This flap is then turned up, giving a wonderful exposure in the right or left upper quadrant. These large kidney tumors I believe should only be attacked through the abdomen. If we try to get them

through the flank we are unable to do anything about the mass of large dilated veins that have developed in the fatty capsule. We get a great deal of bleeding where we cannot reach it, whereas if we have the tumor underneath the hand with the peritoneum open we are able to control the bleeding. The theory is that this anterior approach would enable us to clamp the kidney pedicle before freeing up the kidney. In that way we control the blood supply and also prevent emboli which may be stirred up by handling the kidney from entering the vein. I have never been able to do that, because I cannot reach the pedicle of a large tumor until I get the kidney freed up. It is a good theory but difficult to put into effect. With the abdominal incision one can also much more thoroughly examine the other abdominal organs, the liver and spleen, and make sure that there are no metastases in those. Sometimes we find such an involvement of the lymph glands around the pedicle that we realize at once that nothing can be done to remove the kidney, and then the only thing to do is to close the abdomen. If we are operating by the lumbar incision we cannot feel the pediele until we get the whole kidney freed up; so we may get it freed up only to find that we cannot remove it. I am in favor of the abdominal incision in attacking these tumors, and I find the incision described by Dr. Hugh Cabot to be very satisfactory.

The pre-operative diagnosis here of course is right hypernephroma.

X-RAY INTERPRETATION, FEBRUARY 20

The increased density in the right flank may be due to the presence of a tumor in this area. The linear shadow below the tip of the last right rib may represent calcification in the soft tissues or neoplasm.

The findings show an irregular filling defect of the right kidney pelvis which is consistent with renal neoplasm.

PRE-OPERATIVE DIAGNOSIS

Right hypernephroma.

OPERATION

Ethylene-ether. Incision from tip of twelfth rib to one inch above the umbilicus, then upward halfway to the ensiform. The peritoneum was opened. No metastasis was found in the liver or felt in the abdomen. The posterior peritoneum was incised over the tumor above the hepatic flexure. The tumor was found to be closely adherent to the ascending colon and covered with large veins which bled freely. The tumor was finally freed, the pedicle clamped and the mass removed. It was found impossible to clamp the pedicle before freeing the tumor. A cigarette wick was left in the kidney fossa and brought out through the peritoneal cavity.

PATHOLOGICAL REPORT

A large, spherical solid tumor the size of a child's head, weighing 1640 grams. On section it has a diameter of 19 centimeters and shows a lobulated salmon-red to purplish-red surface with a large area of dirty greenish-brown necrosis. The kidney forms a thick capsule over it. At one aspect there is a projecting nodule of renal substance in which the dilated pelvis and calices, filled with tumor, can be identified.

A microscopic examination shows a structure of large vacuolated cells which line irregular alveolar spaces. Thin-walled blood sinuses separate these alveoli. There are numerous areas of degeneration.

Hypernephroma.

FURTHER DISCUSSION

These operations are rather terrifying because the dilated veins bleed very freely, and the only thing to do is to rip the kidney out as quickly as possible so as to get the pedicle clamped, get the kidney out of the way, and then the bleeding quiets down, because of course these dilated veins drain the kidney and as soon as we have the renal artery clamped they cease to be supplied with blood.

The necrosis of parts of the tumor probably was what provided a medium for the infectious element in this case.

He was given these treatments with deep X-ray therapy in the region of the kidney. I am not at all convinced that this treatment did any good. I have not had much experience with the treatment of hypernephroma metastases with X-ray. There is certainly no use in treating a large hypernephroma, the primary growth, with X-ray, because it is too well supplied with blood and there is no hope of destroying the growth by this means. On the other hand metastases from hypernephroma appear to be susceptible to radiation if they are small and easily radiated, such as a gland in the neck. There seems to be good reason to believe that they can be markedly diminished in size. I should be in favor of treating such metastases by radiation. I think it is just a sop to one's conscience to treat with X-ray a hypernephroma case in which operation has been done, unless we have reason to believe that there is malignant tissue left in the region from which the kidney was removed. There was one such case in the Huntington Hospital where the surgeon who removed the kidney said he knew such tissue was left; the patient was radiated and remained well for several years.

One of the most interesting things about this case is that when he was seen in the Tumor Clinic two and a half years after his operation he was, so far as could be told by external examination, in perfect health. He had no evidences at all of metastasis.

About three years ago Dr. Shoemaker and I looked up the cases of hypernephroma in this hospital,* and I want to speak of the prognosis. We found that twenty-seven cases had the tumor removed. Of those there were four operative deaths, leaving twenty-three discharged from the hospital. Of these five died during the year, two of extension of the disease, three of unknown cause. One case lived four years. Two cases lived eight years and died of carcinomatosis. That is interesting in showing how long after operation a recurrence may appear. One case lived seven years at least but had recurrence then. Six cases had been lost track of. Here are nine results known to be worth while and six unknown results out of twenty-seven.

In this series of cases, sixty-two were explored without removal of the tumor or were not operated at all. Of those that were simply explored or not operated upon it is surprising how long some lived. One man lived as much as seven years after his first symptom. But in general hypernephroma is fairly malignant,—I should say moderately malignant. Yet it is always worth while to try to get out the primary tumor unless the metastases in themselves constitute a contraindication.

DIAGNOSIS

Right hypernephroma.

*G. G. Smith and A. B. Shoemaker, The end result of hypernephroma, Jour. of Urol., Vol. XIV, No. 4.

UNITED STATES PUBLIC HEALTH SERVICE

The Prevention of the Introduction of Disease From Abroad

A striking report has recently been transmitted to Congress by Surgeon General H. S. Cumming of the Public Health Service in which it was shown that the past fiscal year was notable on account of the small numbers of quarantinable diseases that threatened our borders. No cases gained entrance to the country, although 17 cases of smallpox, 2 cases of leprosy, and 2 cases of human plague were apprehended at quarantine stations of the Public Health Service and detained. This fortunate situation was due not only to the system of control at domestic ports, but to the system of medical inspections maintained at certain foreign ports from which diseases are likely to spread on account either of the presence therein of quarantinable diseases or the volume of commerce emanating therefrom.

At domestic ports during the year, 20,284 vessels, 820,793 passengers and 1,140,922 seamen were inspected on arrival by quarantine officers; at insular ports of the United States 2,991 vessels, 169,461 passengers and 226,373 seamen were inspected; at foreign ports 5,954 vessels, 424,172 passengers, and 272,873 seamen were inspected prior to embarking for the United States.

Realizing that the prevention of the importation of epidemic diseases is based on scientific knowledge which is constantly advancing, action has been taken to improve quarantine methods, making them more efficient, more precise, and less burdensome to commerce. Fumigations are based more upon the actual conditions of vessels and less upon routine procedure. On account of their special construction, tank ships afford little harborage for rats. Observation showed that fumigation of these vessels yielded practically no rats, except in certain instances which could have been foreseen by careful inspection. Fumigation of this class of vessels, therefore, is now being done only after inspections which show actual rat infestation.

In order to maintain a vessel in a rat free condition, or at least to have the rat population reduced to negligible numbers, it is necessary either to fumigate at least every six months or that the vessel be rat-proofed. Many steamship companies have come to realize the importance to public health and the economic value of rat-proofing their vessels so that during the past year a great many of the larger passenger ships have been made rat proof and are being maintained in that condition.

The medical examination of applicants for immigration visas in foreign countries of origin by medical officers of the United States Public Health Service, first inaugurated August 1, 1925, in England, Scotland and Ireland, was carried out on a more extended scale during the fiscal year ending June 30, 1927. The demonstrated advantages of the new system to the prospective immigrants, to the communities of origin, and to transportation companies resulted in additional requests to the State Department for the extension of the plan to other countries. As a result of official representation and agreement, medical examinations by Service officers were inaugurated July 1, at five American consulates in Germany, namely, Berlin, Bremen, Cologne, Hamburg and Stuttgart; at Bergen and Osle, in Norway, July 15, 1926; at Copenhagen, Denmark, July 19, 1926; at Goteberg and Stockholm, Sweden, and at Warsaw, Poland, September 1, 1926. These additions increased to 20 the total number of American consulates where medical examinations of applicants were made during the fiscal year, representing 11 countries, counting North Ireland and Scotland as separate countries.

During the fiscal year ending June 30, 1927, a total of 148,539 applicants for immigration visas were given medical examinations. Of the total examined 12,987 or 8.74 per cent., were found to have mental or phtysical disabilities; 6,580, or 4.43 per cent. of the total examined were refused visas for medical reasons.

The advantages of making medical examinations of aliens prior to departure are now generally recognized.

CANCER IN MICE REPORTED CURED BY ELECTRICAL TREATMENT

Dr. J. W. Schereschewsky is in charge of a study involving the application of a high frequency oscillating current to mice which have artificially induced cancer. A certain number have been cured. The dosage of this electrical current has not been definitely determined for it will sometimes kill the animal.

The work is being carried on at the Harvard Medical School coöperating with the Massachusetts Department of Public Health.

Dr. Schereschewsky is reticent about the report, for he feels that sufferers with cancer may be led to believe that scientific work has progressed farther than is correct.

Another unpleasant result of publicity is sometimes found in the claims of pretenders that by the use of such agents patients are deceived and exploited.

Case Records

ANTE-MORTEM AND POST-MORTEM

AS USED IN WEEKLY CLINICO-PATHOLOGICAL EXERCISES

AT THE

MASSACHUSETTS GENERAL HOSPITAL

Published under the direction of

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CABOT CASE RECORDS

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AUTHORS OF CLINICAL DISCUSSIONS

Other than Dr. Richard C. Cabot and Dr. Edward L. Young, Jr.

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RING OUT THE OLD, RING IN THE NEW

IN the course of human progress discretion and valor may enter into the modification of even long continued effort in a given direction to bring about adjustment to modern needs.

Even the long and honorable career of THE BOSTON MEDICAL AND SURGICAL JOURNAL does not compel inflexibility of method and purpose. The eminent men who founded and maintained this JOURNAL for the larger part of one hundred years probably did not intend to hedge it about with rigid and uncompromising adherence to plans and regulations which would prevent acceptance of changes reflecting the knowledge and ambitions of a later period. They were imbued with a spirit of service which conformed to the understanding of the time but which also recognized any sound contribution to the science and art of medicine and quickly adjusted themselves to established facts.

This spirit of temper radiated from the pages of the JOURNAL under their control, and the recital of the history of the JOURNAL, as compiled by several writers of articles, (which will appear in the next issue) portrays the character of these men.

We are proud of the record of New England physicians as it appears in the pages of the JOURNAL and realize the responsibility resting upon us to meet the expectations of those who feel that New England physicians will always be found in the front rank of medicine. We do not say farewell to THE BOSTON MEDICAL AND SURGICAL JOURNAL for the changes consist only in the turn of a page and the donning of a new title in continuation of a larger and more comprehensive publication.

"TOBACCO AND PHYSICAL EFFICIENCY"

ANY attempt to discredit the use of tobacco is to the average smoker like waving a red flag before an angry bull. The subject, unfortunately for the interests of truth, is one on which the investigators, by and large, are divided into two camps—either they smoke and are attempting to justify the habit or they do not smoke, and of those who do not smoke it seems as if a large number refuse to do so militantly. Unfortunately, also, for the interests of truth, so much semi-religious and quasi-moral cant has been injected into the discussion that the honest devotee of a well-fumed briar becomes immediately suspicious, and with reason, of every attempt to make uncomfortable the indulgence of his weakness.

Eventually, however, every important act of mankind becomes the object of sincere and truth-compelling investigation, and this has become the case with tobacco-using under the activities of The Committee to study the Tobacco Problem—a committee composed of a number of individuals of unquestioned ability and irreproachable sincerity. Mingled with the function of this committee we find no kill joy attitude and no patronizing prohibitionism; they are an earnest group of scientific workers, investigating a possible cause of disease.

Under the auspices of this committee "Tobacco and Physical Efficiency", a Digest of Chemical Data has been prepared by Pierre Schrumf-Pierron, M.D., Professor of Clinical Medicine at the University of Cairo, Egypt, with a preface by Doctor Henri Vaquez, Professor of Medicine at the University of Paris. Nothing new is revealed in this book, it is an attempt to analyze and summarize the mass of scientific data which has been collected on the tobacco problem. Throughout it is sane and moderate in its statements, but one is left with the conviction that tobacco contains a drug or drugs which may be distinctly harmful when used in excess or by sensitive individuals.

The chief poison in tobacco is nicotine, discovered in 1809; a volatile alkaloid similar in its properties to curare. In addition to nicotine the smoke contains pyridine, carbon monoxide,

traces of hydrocyanic acid, phenols and aldehydes. The "strength" of tobacco depends largely on volatile oils resulting from the curing process, in which various types of fermentation occur. Habitual users of tobacco may absorb comparatively large doses and may easily tolerate from 40 to 50 mgms. of nicotine a day.

The effects of the excessive use of tobacco on the various systems of the body as noted by various observers have been analyzed, and it seems apparent that most of the systems may become affected. Thus, as regards the nervous system, it is known that tobacco may cause headache, migraine, vertigo, insomnia, mental depression and amnesia. Many cardiovascular neuroses and disturbances of heart rhythm, notably premature contractions, may result from its abuse, and it may, secondarily, bring on hypertrophy of the heart. Its possible rôle in the causation of actual lesion of the heart or arterial change has not been proved. Chronic laryngitis is a well-known effect of overindulgence, and in chronic nicotine poisoning "smokers' asthma", due to incipient paralysis of the breathing centers may result. These symptoms disappear as soon as smoking is refrained from. The digestive symptoms of smokers are of nervous origin and due to chronic irritation of the nerve centers. No urinary symptoms have been observed, although various observers have noted that habitual overindulgence by men may cause partial impotence. Pruritus and urticaria have been attributed to the chronic abuse of tobacco.

In conclusion the author is compelled to admit that the study of the action of tobacco is still incomplete. As with alcohol the problem is the same: "A sound individual may bear what is for him moderate doses without injury, but even these are often noxious to the unsound or other sound individuals. But the immoderate use of tobacco brings on a series of disturbances which are at first functional, then organic, and of which some are not without gravity."

These disturbances have become more frequent as the consumption of tobacco has increased, which has occurred principally in cigarette smoking. The cigarette habit is a result of smoking made easy; it has been greatly increased as a result of the war; it is more noxious because of the greater degree of inhalation associated with it.

The last paragraph shows the moderation with which the study has been made: "Lastly, if one desires to convince the public of the danger of excessive indulgence in tobacco there must be no exaggeration, and tobacco must not be placed, as some writers have placed it, on the same plane as morphine and cocaine. That kind of propaganda leads, in general, to the opposite of what one wishes to attain."

THIS WEEK'S ISSUE

CONTAINS articles by the following named authors:

MORSE, JOHN LOVETT. A.B., A.M., M.D. Harvard Medical School 1891. Professor of Pediatries Emeritus, Harvard Medical School, Consulting Physician at Children's and Infants' Hospitals. Member: New England Pediatric Society, American Pediatric Society, Association of American Physicians and Boston Obstetrical Society. His subject is: "The Thymus Obsession." Page 1547. Address: 483 Beacon Street, Boston.

EPSTEIN, SAMUEL H. A.B., M.D. Harvard Medical School 1927. House Officer, Neurological Service, Boston City Hospital. Address: Harvard Medical School, Boston. Associated with him are:

FARNHAM, R. K. A.B., M.D. University of Vermont 1926. House Officer, Neurological Service, Boston City Hospital. Address: Boston City Hospital, Boston, and

COBB, STANLEY. A.B., M.D. Harvard 1914. Bullard Professor Neuropathology, Harvard, Visiting Neurologist, Boston City Hospital. They write on: "The Use of Salicylates in the Treatment of Chronic Epidemic Encephalitis." Page 1552. Address: Harvard Medical School, Boston.

The Massachusetts Medical Society

SECTION OF OBSTETRICS AND GYNECOLOGY

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Prophylaxis and Treatment of Postpartum Hemorrhage:

Loss of blood from the body is physiological only in menstruation and in parturition, but may become pathological in either of these states by virtue of excess in quantity. Some bleeding is inevitably associated with childbirth, and when this is excessive during or after the third stage it is called postpartum hemorrhage.

Postpartum hemorrhage is a condition which does not depend so much upon the actual quantity of blood lost as upon the effect of this loss upon the general condition of the patient. We find this effect greatly at variance in different individuals, and whereas one patient will bear with ease the loss of a large amount of blood the next will react alarmingly to the escape of a much smaller quantity, most especially if her pregnancy has been complicated by anemia or any of the toxemias.

Diagnosis of postpartum hemorrhage is simple, and consists in the recognition of loss of blood in such quantity as to affect the patient's general condition. The cause of the hemorrhage

may usually be looked for in either partial or complete atony of the uterus or in lacerations of the birth canal, either of which can be determined if the third stage is intelligently conducted.

Normally after birth of the baby and the expulsion of residual liquor amnii the uterus relaxes for a short period before its rhythmic contractions are resumed. During this time and until the placenta separates there is no bleeding unless the birth canal has been lacerated, and even in this case the blood loss is minimal if only the perineum or vaginal wall has been torn. Lacerations, however, in the cervix or in the region of the crura of the clitoris not infrequently give rise to persistent bleeding. Diagnosis of this type of hemorrhage is made by exposure of the affected part, in the case of the cervix by pulling it down to the vulvar orifice by means of hooks attached to its anterior and posterior lips, and in the case of crural bleeding by simple retraction of the labia. Treatment in either locality consists in ligation of the bleeding area by catgut on a curved needle passed proximal to the torn vessel. Care must be taken in the case of a crural tear not to include the urethra in the stitch, and it is well to have a catheter passed into the bladder while the repair is being made.

Most postpartum hemorrhage, however, finds its origin in atony of the uterus following partial or complete separation of the placenta. So long as the placenta is wholly attached to its site in utero there will be no postpartum bleeding in the absence of lacerations of the birth canal. When, however, the placenta separates the maternal blood sinuses in the uterine wall are uncovered and will inevitably bleed unless the uterus contracts down to close them off. Normally this happens during uterine contraction, so that such blood loss as occurs is intermittent, corresponding to relaxation of the organ and ceasing again when the next contraction occurs, this sequence being repeated until the placenta is completely separated from its attachment and is expelled spontaneously or by expression by hand. After the placenta is born the uterus normally contracts permanently and passes into a state of retraction when retraction has definitely occurred the danger of hemorrhage exists no longer.

Postpartum hemorrhage is best treated prophylactically by

1. Avoidance of premature and unwarranted steps to expedite delivery of the baby through an incompletely dilated os. The use of large doses of pituitrin during the first stage and attempts to deliver the baby by accouchement forcé or application of forceps before full dilation are especially to be avoided.

2. Careful and methodical conduct of the third stage, not attempting to expedite delivery of the placenta until it is fully separated. Attempts to deliver the placenta by premature Credé or by traction on the cord are to be condemned. While pituitrin may be used in 0.5 c.c. doses after the baby is born, ergot should never be administered by mouth or hypodermically until the uterus is completely empty.

3. Careful attention to the state of the uterus for at least forty-five minutes after delivery of the placenta, or until complete retraction is definitely established.

When a postpartum hemorrhage occurs the physician should

1. Determine the source of the bleeding, whether from a laceration or from an atonic uterus.

2. If from a laceration, proceed as above outlined.

3. If from an atonic uterus,

   a. And the placenta is still unborn

      (1) Stimulate uterine tone by gentle massage of the fundus through the abdominal wall, external application of ice to the fundus, and exhibition of pituitrin.

      (2) If this is unavailing, remove the placenta manually under strict aseptic precautions, using a freshly boiled rubber glove for the purpose.

   b. And the placenta has been delivered

      (1) Stimulate uterine tone by vigorous massage of the fundus, external application of ice, and exhibition hypodermically of pituitrin and ergot.

      (2) If the above are unavailing, pack the uterine cavity with a three yard gauze packing strip. Such a strip, sterilized and ready for immediate use, should never be omitted from any obstetrical layout, as the need for it is urgent if it occurs. Packing the uterus acts both as a tamponnade and as a powerful stimulant to uterine contraction, and the pack should be left in situ for from ten to twelve hours before being removed.

Questions of a similar nature to the above will be discussed in the JOURNAL each week. They may be addressed to the Clerk of the Committee, in care of the JOURNAL and will be answered by members of the Committee of the Section of Obstetrics and Gynecology.

BOSTON MEDICAL LIBRARY NOTES ON CURRENT LITERATURE AND RARE BOOKS

IN these days when so much research is being directed to those leads that point to dietary deficiencies it is impossible too frequently to call attention to their importance. Within the memory of most middle-aged practitioners Scurvy was the only disease in which such a cause was

at all generally recognized. Since then Beriberi, Rickets, Pellagra and now Pernicious Anemia have been added to the list. In most of these examples the dietary deficiency is not per se the cause of the disease in question but apparently sets the stage for bacteriologic factors to play their role. To bring home concisely to those whose familiarity with the progress of events in the scientific fields where these things are happening must of necessity be limited, the Library will try to present from its resources some of the scientific data upon which Pernicious Anemia, has come to take its place in this group. This presentation will be open to inspection in Holmes Hall (not as previously stated, in the Fifield Room) at the Library from February 20th, to 25th., during the regular Library hours. The Library invites those to whom old books and ancient medical history and biography are a lodestone to keep in touch with our acquisitions to which additions are frequently being made through the generosity of friends. Some of the more recent gifts will be here briefly noted from time to time.

The Christianismi Restitutio, of Michael Servetus.

The 300th anniversary of William Harvey's publication of his "De motu cordis" naturally brings to mind the tragic ending of Michael Servetus who first described the pulmonary circulation in his Christianismi Restitutio, 1553.

Michael Servetus, born 1509 or 1511 at Villeneuve in Aragon, was a fellow student with Vesalius in Paris and a practitioner of medicine for twelve years at Vienne near Lyons. He was burned at the stake as a heretic in 1553 at the instigation of Calvin. During his life in France he was known as Dr. "Villeneuve". Servetus entered the University of Sargossa in Spain when fourteen. He studied law at Toulouse for two years and science at Paris in 1532-1534 where he first met John Calvin who later was the cause of his death. Subsequently he went to Lyons as editor and came under the influence of Symphorien Champier.

From Lyons Servetus returned to Paris where he became acquainted with Vesalius, studied anatomy with him under Joannes Guinterus, and took his degrees of M.A. and M.D. at the University of Paris. It was here that he obtained the anatomical knowledge that enabled him to describe the pulmonary circulation.

In 1537 Servetus published his medical treatise on "Syrups and their use in medicine" printed by Simon Colin. From Paris he went to Vienne and in 1531 published his "Errors of the Trinity" and in 1553 his "Christianismi restitutio". It is in this work on Pages 170 and 171 that Servetus described the pulmonary circulation.

In 1553 Servetus was denounced by Calvin, was tried at Vienne for heresy but was allowed to escape from jail by the friendly authorities. On June 17th he was condemned in his absence to be "burned alive with his books by a slow fire". The sentence delivered, it was ordered to be carried out forthwith on an effegy. This sentence was done and 499 copies were burned at the stake. Servetus had escaped to Geneva. He was apprehended, tried, convicted, and burned to death on October 27, 1553.

The Christianismi restitutio was printed secretly, and the impression was said to be 1000 copies. The entire edition was made up into bales of 100 copies each. Five bales were sent to Lyons, two or three to Frankfort, and the remainder were stored in Chatillon. In April, 1553, the five Lyons bales containing five hundred copies were seized. One copy was abstracted and the balance later burned on June 17th. It was probably never exposed for sale as no copies were obtainable after Servetus' execution. Willis stated that not more than five copies ever left the bales after they were packed. The remaining 995 were burned. The book remained unknown until 1694 when Wotton in his "Reflections on Learning" called attention to the passage on the pulmonary circulation.

Of the original edition of 1000 only two complete copies are now known to survive; one in the Royal Library at Vienna, the other in the National Library at Paris. The Paris copy formerly belonged to Dr. Richard Mead and in 1723 he began a reprint in quarto size, but when half finished it was seized and burned at the instigation of Gibson, Bishop of London. A few copies must have been overlooked as one is now in the Library of the London Medical Society.

In 1790 Dr. C. T. DeMarr made a reprint of the Vienna copy using the same format, copying the original line for line and word for word. It is said to have been printed at Nuremberg and is identified by the date 1790 printed in very small type on the last page.

According to Willis, Dr. G. Sigmond was the first medical man to give an account of Servetus' physiological and psychological opinions from an actual survey of the "Christianismi restitutio". His book is called "The unnoticed theories of Servetus", was published at London in 1826 and is very rare as it was suppressed by the author. It was written in English and Latin and he discusses the opinions of Servetus on the phenomena of the mind, on the pulmonary circulation and on animal and vegetable life. Sigmond remarks that Servetus after giving his description of the pulmonary circulation, states the reasons for his belief in his doctrine of the circulation and observes that Galen was unacquainted with the truth.

MISCELLANY

THE ACTIVITIES OF THE COMMONWEALTH FUND

New York, Feb. 6.—The expenditure of $1,100,000 last year by the Commonwealth fund in efforts to improve the physical and mental health of American children is described in the ninth annual report of the General Director, Barry C. Smith, published February 6. Other gifts for hospitals, educational and welfare work brought the total appropriations for the fiscal year ending September 30, 1927 to $1,953,557.

The capital endowment of the Commonwealth Fund, which was established in 1918 as a general philanthropic foundation with an initial gift of $10,000,000 from the late Mrs. Stephen V. Harkness, was increased by additional donations during her lifetime and now amounts to over $38,000,000. The income last year was $2,129,748.

Approximately $417,000 was expended to carry on the Fund's program for the promotion of child health. A five-year demonstration of health work in Fargo, N. D., was completed and the city has made provision for the continuance of every essential activity at its own expense. Fargo's health budget for 1928 calls for an expenditure of $1.13 per capita for health purposes as compared with $.28 in the year prior to the opening of the demonstration. The health work of the city is rated by the American Public Health Association at 814 points out of a possible 1,000 as compared with 320 the year before the demonstration. Similar demonstrations are being continued in Rutherford County, Tenn.; Athens, (Clarke County) Ga.; Marion County, Ore.; and the official scoring of public health activities in these communities already shows gains comparable to that in Fargo.

In Austria where the Fund has aided in the support of various forms of child welfare and health work throughout the post-war period, no attempt has been made to import American public health methods, but standards of existing Austrian child health service have been raised and various extensions of the public health program have been made in accordance with the demands and understanding of each community. In the belief that the best way to improve standards is through the training of workers in strategic points throughout the country, scholarships totaling $39,000 have been given to physicians, midwives, and welfare workers. During the past summer Dr. Thomas Scherrer, Chief of the Austrian Department of Public Health, visited the United States under the auspices of the Fund, traveling as far as the Pacific coast in a two-months' study of American public health work.

The Fund's program for the development of child guidance clinics, visiting teacher work in the public schools, and allied projects in the field of mental hygiene required last year appropriations totaling $697,000. A five-year period of demonstrations and consultant service under this program, ending in June 1927, has resulted in the establishment of community clinics for the study and treatment of children's behavior problems in Cleveland, Philadelphia, St. Louis, St. Paul, Minneapolis, Dallas, Baltimore, Richmond, Milwaukee, Los Angeles, and Pasadena, California. Following a series of three-year demonstrations together with advisory and consultant service, visiting teacher work has been organized in the public school systems of fifty-eight communities located in thirty-two different States. School children to the number of 15,439 have been aided by visiting teachers in the solution of their difficulties in these demonstration centers and in New York City.

An outstanding feature of the Fund's mental hygiene program was the establishment this year of an Institute for Child Guidance in New York City under the direction of Dr. Lawson G. Lowrey. This Institute is fully equipped both for research and for practical work with children who exhibit conduct disorders and personality difficulties. It also provides a center for the special training of psychiatrists, psychologists, and psychiatric social workers. Fellowships established by the Commonwealth Fund for students at the Institute are administered by the National Committee for Mental Hygiene, the New York School of Social Work, and the Smith College School for Social Work.

Through its Division of Education the Fund expended $50,000 for educational research. In June, Max Farrand, who had been director of the division for several years, resigned to accept the position of director of research of the Henry E. Huntington Library and Art Gallery. Under his successor, Edward Bliss Reed, formerly associate professor of English at Yale, the Division is devoting its major attention to administering the fellowships for British graduate students in American universities which the Commonwealth Fund established in 1925. A total of $175,000 was appropriated last year for the maintenance of these fellowships, which permit of two years study and travel in the United States. The first group of Fellows, appointed in 1925, have completed their studies and returned to positions in Great Britain or the Dominions. To the original twenty fellowships the Fund added last year three fellowships for graduate students from the Dominions studying at British universities, and more recently two fellowships for university graduates attached to the British Colonial Service.

For the development of rural hospitals the Commonwealth Fund appropriated $414,000 during the year under review, making awards to Farmington, Maine; Beloit, Kansas; and Wauseon, Ohio. Farmville, Virginia, and Glasgow, Kentucky, had received awards the previous year under this program, the objects of which are to provide modern hospital facilities in rural areas where they are needed, to assist in improving standards of local medical practice, and to provide an incentive for good physicians to remain in the country and for young physicians to come there. In accordance with a policy of coöperation which is applied so far as possible in all the Fund's local work it is stipulated that the community shall pay a third of the cost of building and equipping the hospital and undertake its maintenance. The general plan includes the construction of fifty-bed general hospitals in the selected areas, the development where advisable, of facilities for the training of nurses; provision for preventive and educational clinics as a part of out-patient service; fellowships to local physicians for post-graduate study; educational institutes and clinics for physicians; and the development of community public health activities in coöperation with the hospital.

Miscellaneous grants totaling $182,000 made by the Fund last year included appropriations to the American Conference on Hospital Service, the American Society for the Control of Cancer, the Foreign Language Information Service, the League of Red Cross Societies for the forthcoming international conference of social work, the Welfare Council of New York City for its research program, the New York Tuberculosis Association, and other health and welfare agencies.

AN EXPRESSION OF SYMPATHY AND ENCOURAGEMENT

Our attention has been called to an editorial in the *Iowa State Medical Society Journal* in which two mis-statements occur. First, that the financial condition of the BOSTON MEDICAL AND SURGICAL JOURNAL is precarious. The facts are that the Massachusetts Medical Society owns the JOURNAL and the corpora-

tion is in sound financial condition. The burden of carrying the JOURNAL is not regarded as excessive. This JOURNAL is the only state JOURNAL published every week which seems to indicate support. Second, the *Iowa Journal* reports that Walter J. Walker is the Editor. So far as we have been able to learn no one by that name was ever connected with this JOURNAL.

The *Iowa Journal* commends the policy of uniting with other New England States in the publication of a journal.

AFFAIRS OF THE EYE SIGHT CONSERVATION COUNCIL OF AMERICA

Re-election of Lawrence W. Wallace of Washington as President of the Eye Sight Conservation Council of America, which is directing a national movement for eye conservation in education and industry, is announced, following the annual meeting of the Council.

Mr. Wallace, who is the Executive Secretary of the American Engineering Council, actively directed the work of the Hoover Committee on Elimination of Waste in Industry, which found that much economic and social waste was attributable to defective vision among industrial workers.

Guy A. Henry of White Plains, N. Y., was again chosen General Director of the Eye Sight Conservation Council, which from headquarters in New York City is conducting extensive field activities carrying the message of eye care particularly to the pupils, parents and teachers of the country.

The Field Secretary, Mr. Chas. F. Southard, visited 67 cities in eleven states during 1927 and delivered 650 addresses to a total estimated audience of 341,700. During the past five years the Field Secretary of the Council has covered 29 states, visiting 389 cities, delivering 2937 addresses to audiences totaling 1,425,150.

The field work of the Council is being expanded and made more intensive in the various localities visited and the coöperation of various civic, health and welfare organizations enlisted. During 1928 field activity will be extended into new territory, special attention being given to the educational field. Poor eyes, investigations disclose, are a factor in retardation among school children.

Bailey S. Burritt, General Director of the New York Association for Improving the Conditions of the Poor, was re-elected Vice-President and William R. Wall of New York continues as Treasurer.

R. M. Little of Albany, Director of the Bureau of Rehabilitation, New York, State Department of Education, was elected a Director of the Council to serve three years, the other Directors are, F. C. Caldwell, A.B., M.E. of Columbus, Ohio, Professor of Electrical Engineering, Ohio State University, an authority on lighting and an active committeeman of the Illuminating Engineering Society. Morton G. Lloyd, Ph.D. of Washington, D. C., Chief of Safety Section of the U. S. Bureau of Standards, and a former Vice-President of the Illuminating Engineering Society.

Among those elected to the Board of Councillors of the Eye Sight Conservation Council for 1928 is, Dr. Frederick B. Robinson, LL.D., President of the College of the City of New York. Other Councillors chosen are:

James J. Davis, Secretary of Labor; Dr. Arthur L. Day, Director of the Geophysical Laboratories of the Carnegie Institution of Washington; Prof. Charles H. Judd, Director of the School of Education, University of Chicago; Prof. Joseph W. Roe, head of the Department of Industrial Engineering in New York University; G. E. Sanford, Schenectady, N. Y., Past President of the American Society of Safety Engineers; Richard E. Simpson, research engineer of Hartford, Conn.; Dr. John J. Tigert, U. S. Commissioner of Education; Prof. Thomas D. Wood, Teachers College, and James T. Grady, Department of Public Information, Columbia University.

During the coming year, it is announced, the Council will work with Better Business Clubs throughout the country to stamp out fraudulent traffic of concerns offering to fit glasses by mail. It is claimed that an offer to fit glasses by mail is a dishonest offering simply because it purports to do that which is impossible. Those who are being exploited by such tactics may suffer irreparable damage to their eyes.

STUDY OF ANTHROPOLOGY BY PHYSICIANS ADVISED AS AID IN COMBATTING DISEASE

The value of anthropology to medicine is better appreciated in Europe and even in Japan and China than in the United States, Dr. Alex Hrdlicka, of the Smithsonian Institution, stated on December 28 in an address in Nashville, Tenn., at a meeting of the American Association for the Advancement of Science.

The speaker said that while no first-class medical school abroad is without courses in physical anthropology, in America such courses are given in the medical schools of but seven leading universities. He named Johns Hopkins, Harvard, University of Virginia, Western Reserve, Washington University at St. Louis, University of Chicago and Stanford. Dr. Hrdlicka said:

"More dentists than physicians subscribe to anthropological journals, and the vast collections of both normal and pathological material in our osteological, brain and other collections, is used nowhere near as much as it should be by the medical man and the surgeon.

"In human evolution medicine will find the key to the deeper causes and the trends of a large part of human pathology, and the effect on pathology of race and type. The lesson of human variation for medicine is that everything about us—our frame, organs, functions, the causes of our diseases, and disease itself—are subject to a substantial range of normal variation.

"Physical anthropology shows, for example, that the normal stature of an adult American male is not 5 feet 7½ inches, but anywhere between, say, 5 feet 4 inches, 6 feet 3 inches. The normal male pulse is not invariably 71.5, but ranges between 66 and 78 per minute. The normal pelvis, head, and any other part or organ, may show as much as 10 to 16 per cent. normal variation in size, with a considerable variation in form. The 'normal' course of lobar pneumonia or any other affection is not 'just so,' but will oscillate between such and such limits.

"As to the determination of standards, it is self-evident that the medical man to judge properly must have normal standards of the parts in which he is interested at the time, in the particular people with whom he is dealing. And to find these standards (or averages) with their range or normal (non-pathological) variation, is the peculiar function of anthropological endeavor."—*U. S. Daily.*

DR. OTIS HONORED

One hundred and fifty members of the staff of the Boston Dispensary and guests were present at a dinner held at the University Club, Tuesday evening, January 31st, in honor of Dr. Edward O. Otis. The occasion marked the completion of forty-two years' service to the people of Boston as a member of the staff of the Dispensary.

Dr. Maynard Ladd, President of the Dispensary Staff Association, presided. He referred to Dr. Otis as "the grand old man of medicine," internationally

known and respected for his work in the field of tuberculosis.

On behalf of the Staff Association, Dr. Ladd presented to the guest of honor a humidor with a suitably engraved silver plate.

Dr. Otis, who has been a member of the Massachusetts Medical Society for many years, was also President of the Massachusetts Tuberculosis League from 1919 to 1925.

Dr. Ladd, in presenting Dr. Otis to the meeting, gave the following account of his life and work:

EDWARD OSGOOD OTIS

Born Rye, N. H., October 29, 1848.

He came of old New England stock; his earliest ancestor in America was John Otis, who came from Devonshire, England, and settled in Hingham, Mass., in 1635.

Fitted for college at Phillips Exeter Academy.

A.B. Harvard, 1871. Phi Beta Kappa.

M.D.Harvard 1877.

Sc.D. (honorary) Tufts College; Sc. D. (honorary) New Hampshire Univ.

Medical and Surgical house officer, Boston City Hospital, 1877.

(Serving with Dr. Otis H. Marion, later of Brighton, and Dr. George A. Leland.)

Has practiced in Boston since 1880.

In his early practice, Dr. Otis seemed to incline to surgery; in 1884 he contributed " a report on antiseptic surgery", which he read before the New Hampshire Medical Society, at its meeting in Concord.

In 1886 he was appointed SURGEON to the Boston Dispensary;

(Among other appointees to the Surgical Staff at about this time, we find the names of Samuel J. Mixter, Herbert L. Burrell, George H. Monks, and William M. Conant.)

Further evidence of his interest in surgery:—In 1886 Otis contributed a paper published in BOSTON MEDICAL AND SURGICAL JOURNAL, "Backward Dislocation of the Fingers upon the Metacarpus"; in 1887 "Injuries and Operations upon the Kidney"; but in 1889 we find him inclining toward that department of medicine which was to be the major part of his life work, as evidenced by his published paper, "The psychological Factor in Selecting A Climate for Invalids," and a few years later, "Climatic Therapeutics in the Treatment of Pulmonary Tuberculosis."

In 1891, we find his office located at 93 Mt. Vernon Street; a member of the New Hampshire Medical Society as well as of the Massachusetts Medical Society; a member of American Academy of Medicine; the Boston Society of Medical Observation; Boston Society of Medical Improvement; American Association for the Advancement of Physical Education; the American Climatological Association, and Medical Director of the B. Y. M. C. Union Gymnasium.

Always and continuously since Dr. Otis' appointment to the Staff of the Dispensary in 1886 (*42 years ago*), he has been tireless in working for its interest; we find him a member of the Committee on Building and Finance in 1897; superintendent for many years.

(Serving from 1900-1904, following Dr. Wm. H. H. Hastings.)

Appointed Professor of Pulmonary Diseases and Climatology, Tufts College Medical School in 1901.

Was formerly Visiting Consulting Physician to the Rutland State Sanatorium.

Has been connected with work of prevention of tuberculosis in Nation, State and City for more than 25 years.

Visiting Physician to the Home of Comsumptives.

Contract Surgeon in the World War.

Member of Medical Board of the Loomis Sanitarium.

Former President of the National Tuberculosis Association, and American Public Health Association.

President of American Climatological Association in 1898.

In 1901, a delegate to the Congress on Tuberculosis in London.

In 1912, a delegate from the United States to the International Convention on Tuberculosis, held in Rome.

Author:—

"Tuberculosis: its Cause, Cure and Prevention," 1909. (a book for laymen) and a frequent contributor to Medical Literature for years.

No bibliography on any matter to do with tuberculosis is complete without the name of

OTIS

On behalf of the Staff Association, Dr. Ladd presented to the guest of honor, a handsome humidor, with an appropriately engraved plate.

Arthur G. Rotch, President of the Boston Dispensary, also paid tribute to the self-sacrificing devotion of Dr. Otis, in his long career at the Institution.

The Board of Managers of the Dispensary was represented at the dinner in addition to the President, by Robert W. Maynard, Ashton L. Carr, Albert Green Duncan, Miss Kate McMahon, Archibald Monks and Frank E. Wing, Director.

Preceding the dinner, a business meeting of the Dispensary Staff Association was held, at which the following officers were elected:

President—Dr. Maynard Ladd.

Vice-President—Dr. Augustus Riley.

Secretary-Treasurer—Dr. Joseph A. Skirball.

In responding to the address of tribute and presentation by Dr. Maynard Ladd, Dr. Otis reviewed the early history of the Dispensary, when the staff and employees combined, did not exceed ten. He traced the development of the Institution from those early struggles up to its present position of high standing in the City.

Dr. Otis also gave reminiscences of his recent trip around the world. He expressed the hope that he would live to see the Dispensary considerably enlarged, with much augmented modern equipment for advanced medical and surgical work, and suitable quarters for the comfort of the growing staff.

LEGISLATIVE NOTES

Several years ago the Legislature provided that suits for "Malpractice, error or mistake" against physicians, surgeons, dentists, hospital and sanitaria should be "commenced only within two years next after the cause of action accrues."

The enactment of this law introduced no new principle. It simply extended to Malpractice cases the law dealing with suits for assault and battery, for false imprisonment, for slander, for actions of tort, for personal injuries and for other similar matters. The inclusion of Malpractice suits in this group was simply an act of justice because the witnesses upon whom a physician or surgeon must depend for his defense are for the most part nurses, attendants and assistants who after a couple of years may be entirely out of reach even if their names can be recalled.

A bill has been introduced in the Legislature (House 748) which would render the present law ineffective. It is proposed to permit suit for Malpractice to be commenced within two years after the cause of action "*becomes known.*" If this bill is en-

acted the two year limitation would for all practical purposes be wiped out. All who are interested in promotive suits for Malpractice will doubtless exert their influence in favor of the bill.

If the bill is to be defeated physicians and dentists must interest themselves enough to show their Senators and Representatives the reasonableness and justice of the present law. It is difficult if not impossible to conceive of a genuine ground for a Malpractice suit remaining unknown for over two years. Such a thing is practically impossible. If in one case in ten thousand such a thing happened the thousands of cases in which it could not happen must not be forgotten. The just and fair provisions of the present law should be maintained.

House—No. 748

Section 1. Section four of chapter two hundred and sixty of the General Laws, as amended by section one of chapter three hundred and nineteen of the acts of nineteen hundred and twenty-one, is hereby further amended by inserting after the word "accrues" in the ninth line, the words:—or becomes known,—so as to read as follows:—Section 4. Actions for assault and battery, false imprisonment, slander, actions against sheriffs, deputy sheriffs, constables or assignees in insolvency, for the taking or conversion of personal property, actions of tort for injuries to the person against counties, cities and towns and actions of contract or tort for malpractice, error or mistake against physicians, surgeons, dentists, hospitals and sanitaria, shall be commenced only within two years next after the cause of action accrues or becomes known; and actions for libel shall be commenced only within one year next after the cause of action accrues.

Section 2. This act shall take effect upon its passage.

House—No. 62

Petition of Francis X. Coyne for the repeal of the law permitting counties to make adequate hospital provisions at state sanatoria for their tuberculous patients has been referred to the next annual session.

The vaccination bills, House Nos. 595, 596, 597 and 793, are all to be heard February 27.

House—No. 273

The petition of Henry W. Jarvis for the restriction of the use of habit forming drugs in state hospitals for the insane has been given leave to withdraw.

House Bill No. 788 provides that physicians' prescriptions shall be written triplicates, one to be kept by the prescriber, one by the druggist, and one by the person for whom the prescription was written.

House Bill No. 789 provides that physicians, surgeons, or other practitioners who prepare or dispense medicine, drugs, or remedies shall place a label on the bottle or package containing the medicine giving the contents and ingredients therein. This act does not apply to wholesale druggists and registered pharmacists.

House Bill No. 790 requires that prescriptions shall be written in English.

House—No. 789

Petition of John J. Kennedy relative to the labelling of medicines, drugs or other remedies so as to show the contents and ingredients thereof will be heard February 20.

House—No. 791

An Act relative to the Qualifications of Applicants for Registration as Nurses.

Section 1. Section seventy-four of chapter one hundred and twelve of the General Laws is hereby amended by striking out the words "approved by the board" in lines eight and nine, and inserting in their place the words:—which gives a full three years' course of instruction in connection with a legally chartered hospital of a capacity of not less than fifty beds, supplying general medical, general surgical ,and obstetrical services,—so as to read as follows:—The board of registration of nurses, herein and in the seven following sections called the board, shall hold examinations for the registration of nurses and shall give notice of the times, places and subjects of such examinations, by publication in one or more newspapers in each county. Applications for registration, signed and sworn to by the applicant, shall be made on blanks furnished by the board. An applicant who furnishes satisfactory proof that he is at least twenty-one, of good moral character and a graduate of a training school for nurses, which gives a full three years' course of instruction in connection with a legally chartered hospital of a capacity of not less than fifty beds, supplying general medical, general surgical, and obstetrical services, shall, upon payment of five dollars be examined by the board, and, if found qualified, shall be registered, with a right to use the title registered nurse and to practice as such, and shall receive a certificate thereof from the board, signed by its chairman and secretary. An applicant failing to pass an examination satisfactory to the board shall be entitled, within one year thereafter, to a re-examination at a meeting of the board called for the examination of applicants, without the payment of an additional fee. Every person registered hereunder who continues to hold himself out as a registered nurse shall, on or before December thirty-first in each year renew his registration for the ensuing year by payment of fifty cents to the board, and thereupon the board shall issue a certificate showing that the holder thereof is entitled to practice as a registered nurse for the period covered by said payment. In default of such renewal, a person registered hereunder shall forfeit the right to practice as a registered nurse or to hold himself out as such until such fee shall have been paid. The board may, after a hearing, by vote of a majority of its members, annul the registration and cancel the certificate of any nurse; and, without a hearing, may annul the registration and cancel the certificate of nurse who has been found guilty of a crime.

House—No. 941

An Act enlarging the Purposes of the Boston Medical Library.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Boston Medical Library, a corporation established on May seventh, eighteen hundred and seventy-seven, under general law under the name of Boston Medical Library Association, and the title of which was changed to its present title under the provisions of chapter three hundred and sixty of the acts of eighteen hundred and ninety-one on May fourth, eighteen hundred and ninety-six, shall have, so far as the same may be additional to its present purposes, the following purposes, to wit:—promoting and advancing medical science and medical education.

CORRESPONDENCE

NOTES ON THE CONGRESS ON MEDICAL EDUCATION IN CHICAGO

February 6, 1928.

Editor of The Journal:

Enclosed, you will find a clipping, which may be of value to you, as a preliminary report on the Congress.

Sir Norman Walker spoke at length upon British methods of education and examination. It was a scholarly address and deserved the applause accorded.

Dr. Wm. S. Thayer, Pres.-Elect. of A. M. A., discussed Sir Norman's paper, and spoke of the Boston City Hospital as being a leader in medical education. He congratulated the Board of Trustees as being composed of high-idealed and far-sighted men who were able to visualize the future to such an extent, that they combined the interests of Harvard Medical School, the staff of the hospital, and the public welfare, that the community at large might be benefited. "We find here, research men and clinicians, directing men in special lines, in dietetics, laboratories and X-ray investigations, and then utilizing the knowledge obtained, for the primary benefit of the sick. Too often the sick man is overlooked in the study of scientific medicine."

Later in the morning session, a most impressive thing occurred when Dr. Bevan introduced Dr. Longcope, who read a paper on the value of medical clinics which paper was written by Dr. Francis Peabody during his last weeks, even to his last days.

At the conclusion of the paper, at the suggestion of Dr. Bevan, we arose, and stood for a minute in silent prayer for Dr. Peabody.

In the afternoon session, we heard Dr. Davison, Dean of Duke University School of Medicine, read a paper recommending an M.D. degree five years after high school. It was an impressive paper and gave the student time for interneship as well as special courses later if he so desired.

The Surg. Generals of Army and Navy and U. S. Public Health Service read most interesting papers, mostly on tropical diseases, and successful methods adopted to eradicate them.

Drs. Meaker, Begg, Stearns, Burnham and the undersigned are here, so Boston and Massachusetts are well represented.

I thought that you might be interested in early reports, so am inflicting them upon you.

With kindest regards, believe me to be

Sincerely yours,

THOMAS J. O'BRIEN.

THE CLIPPING

"DIPLOMA MILLS" GONE, SAYS BEVAN

Diploma mills and quack medical colleges have been wiped out in the United States after a twenty-five year fight of education and legislation, it was declared by Dr. Arthur Dean Bevan, professor of surgery at Rush Medical college, in opening the annual congress on medical education in the Palmer house.

"Since 1904 the number of medical schools in the country has dropped from 166 to eighty and the rotten spots which existed in medical education a quarter of a century ago have been absolutely cleaned out," he told the distinguished group of physicians who have gathered for the meeting.

"When we first began our survey of conditions in 1904 the United States had 166 schools, only two of which were grouped as Class A. This number included twenty homeopathic schools and seven eclectic colleges and only two schools required college degrees for entrance. In all the rest of the world at that time there were only 154 schools, most of which were of the finest type.

SIX BAD SPOTS

"There were six distinctly rotten spots in the country, Illinois had 15 schools, Missouri 14, Tennessee 10, Indiana 8 and Kentucky 4. Only 6 of all that number were classed as good schools, and 46 were of a 'doubtful' caliber.

"After the beginning of our campaign against loose educational methods the number of these schools dropped immediately; by 1915 the number had dropped to 99, in 1915 to 86 and today there are only 80. Sixty-two of the schools today are grouped as Class A, 9 as Class A for the two-year course, they give 3 as Class b and only 6 as 'poor.' In another year or two we plan to eliminate all of the last 6."

THE WOMEN'S AUXILIARY

Editor Boston Medical and Surgical Journal:

Dear Sir:

Dr. Crowell has just returned from the councillors' meeting and told me something about the alliance of doctors' wives.

Ten years ago I started an organization here in Dorchester known as, The Dorchester Physicians' Wives Association.

It has quietly prospered, doing charity work in a small way, limited to Dorchester, and now numbering over sixty members.

I should be very glad to know something of this alliance and Dr. Crowell thought you could give me the address of the head of it.

Hoping we might get something which will assist us in our work.

Very truly yours,

NELLIE F. CROWELL.

February 1, 1928.

ESSEX NORTH DISTRICT SOCIETY MAKES ESPECIAL APPEAL FOR THE PAYMENT OF THE ANNUAL ASSESSMENT

February 12, 1928.

Editor Boston Medical and Surgical Journal:

We are mailing together with our second assessment bill, to all members of Essex North, who have not paid 1928 assessment, the enclosed card. Hope we may receive 100% of payments by March 1.

Respectfully,

J. FORREST BURNHAM.

ESSEX NORTH DISTRICT MEDICAL SOCIETY

Dear Doctor:

1. Our BOSTON MEDICAL AND SURGICAL JOURNAL desires that there be no break in its subscription list, in order that it may offer its advertisers proper inducements. (See note in red on enclosed assessment bill.)

2. Our Essex North District Medical Society can expend more for our benefit during the year if assessment is paid promptly. (See note in black.)

3. Above results are possible if assessment is in hands of Treasurer before February 29, 1928, if convenient.

J. FORREST BURNHAM, M.D., *Treasurer*,
567 Haverhill Street, Lawrence, Mass.

February 8, 1928.

NOTES ON NATIONAL AFFAIRS

(*From Our Special Correspondent*)

ENFORCING THE CAUSTIC POISON ACT

The Federal Caustic Poison Law, enacted by Congress on March 4, 1927, at the behest of the organized medical profession, went into actual operation on December 22, 1927, when the President signed the First Deficiency bill, by which funds were made available for the enforcement of this law. The purpose of this act is to safeguard the interstate shipment of certain dangerous caustic and corrosive acids, which is accomplished by requiring proper labelling, with the word "Poison" displayed, as well as directions for first aid.

The enforcement of this law is entrusted to the

United States Department of Agriculture, through its Food, Drug and Insecticide Administration, which has branches in sixteen large cities, the industrial centers of the country. These branches were instructed to inaugurate immediate surveys of the products coming under the terms of the act and to take steps to secure compliance with the labelling provisions. Misbranded shipments may be seized and violators prosecuted. The Food, Drug, and Insecticide Administration has prepared regulations for the enforcement of the act and these may be obtained from the administration in Washington, D. C.

MILK IMPORT LAW IN FORCE

The Federal Import Milk Law, which was adopted on May 15, 1927, in spite of strong opposition from New York and New England dairy interests and health officials, is also now being enforced, an appropriation having been made available by the Deficiency Act. This measure is likewise entrusted to the Food, Drug and Insecticide Administration, which now seems to have many public health duties. The Federal Import Milk Law requires shippers of milk into the United States to get a permit from the Department of Agriculture. Already more than 3800 temporary permits are said to have been issued and the Administration, having organized and equipped the necessary staff, is now engaged in issuing the permanent permits. The Canadian Government is coöperating by making the tuberculin tests required and Canadian inspectors will endeavor to examine milk and cream before shipment and conduct the necessary sanitary inspections.

THE PRESIDENT'S PHYSICIAN

A bill to allow the rank and pay of a colonel in the Medical Department of the Army to the President's personal physician (H. R. 5658) came up in the House on January 16, 1928. On the objection of Representative Blanton of Texas, who declared that the measure was a bad precedent, the bill was put over, that is, deferred for future action. Major James F. Coupal of Massachusetts is at present the personal physician of President Coolidge.

FEDERAL MEDICINE

Bills to regulate the various cults in the District of Columbia, for which Congress acts as local legislature, have been introduced. They include S. 2026 to regulate chiropractic, H. R. 9347 to regulate naturopathy, and there is also a measure to control osteopathy. None of these cults are now regulated at all in the national capital.

Several bills have also been introduced for the purpose of extending free medical care to government employees and to veterans. Thus, there is H. R. 7209, to provide for the care and treatment of naval patients on the active and retired list in Government hospitals when naval hospital facilities are not available; and H. R. 8228, to extend from January 1, 1925, to December 31, 1928, the time when tuberculosis in veterans shall be presumed to be of service origin. Mr. Blanton, as stated in our last letter, also has a bill similar to this.

FEDERAL SUBSIDIES FOR RURAL HYGIENE

Grants of federal funds for rural health work in the states are provided in a bill, H. R. 7005, introduced by Representative Bankhead of Alabama. This measure proposes an appropriation of $1,000,000 a year to be allotted on a rural population basis to states which match the federal grant. The law would be administered by the Public Health Service. This bill, which is similar in its terms to the Federal Maternity and Infancy Act, has been before the last two or three Congresses, so far without result.

AN ALCOHOLIC LIQUOR BOARD

The Department of Agriculture would be enriched by the establishment of a Federal Alcoholic Liquor Board, according to H. R. 8131, introduced by Representative Black of New York. This board of three, each member receiving a salary of $15,000 a year, would grant annual licenses to farm organizations for the processing and selling of beer and wine for beverage, sacramental, and medicinal purposes. The revenue would be devoted to agricultural relief after, we presume, the salaries of the board had been paid.

NARCOTICS

An amendment to the opium importation law, which restricts importation of this drug for legitimate medicinal purposes only, has been offered by Senator Jones. This bill, S. 1602, provides for the deportation of an alien convicted of violation of the narcotic import law, unless such alien has been pardoned or the court hearing his case has recommended that he be not deported.

An extensive article by Richmond P. Hobson, director of the Anti-Narcotic League, on the peril of narcotics appears in the Appendix of the *Congressional Record* for January 18, 1928, having been inserted at the request of the Honorable Hugo L. Black of Alabama.

STUDY OF THE ABNORMAL CLASSES

A laboratory in the United States Public Health Service for the study of the abnormal classes along sociological and pathological lines is proposed by Representative Kindred of New York, one of the few physicians in Congress. His bill, H. R. 177, calls for the appointment of a director, assisted by an anthropologist, a criminologist, a psychologist, an alienist, a neurologist, and a statistician, the director to receive $7,500 a year and his aids $5,000 each. In addition there would be authorized an annual appropriation of $50,000 for equipment.

A LETTER FROM DEAN EDSALL ENDORSES THE COMMUNITY HEALTH ASSOCIATION SERVICE

January 31, 1928.

The service that the Community Health Association offers, to persons who need some nursing service but not a full time nurse—and who are in a position to pay a moderate sum—offers a good deal of comfort to a great many people that may not be familiar with the possibility of getting this service.

It would seem well for physicians and others dealing with people, who are in need of such care, to bring this more clearly to their attention when the opportunity offers. There are, of course, a great many patients that do need some care, but who do not need to undertake the expense of having a nurse for full time work, and who also would be relieved not to have a person about all the time in the family, when not needed except for a short time during the day. When there are special treatments requiring the training of a nurse, or when patients simply require to be bathed or otherwise cared for once a day, as for instance, in cases of post natal care of mother and child after the actual puerperal period is passed, as well as in a good many other cases, such a service would be likely to be a great comfort to a great number of people, as well as a great saving of expense. This service can be obtained and appointments made, by telephoning to the Community Health organization.

DAVID L. EDSALL, M.D., *Dean*.

A LETTER TO MEMBERS OF THE BOSTON CITY HOSPITAL TRAINING SCHOOL FOR NURSES' ALUMNAE ASSOCIATION

My dear Miss:

As you are doubtless very well aware, the year 1928 marks the fiftieth anniversary of the foundation of The Boston City Hospital Training School for Nurses and should receive some recognition from its graduates, who have always been mindful of the dignity of their school and the importance of its position in the galaxy of great institutions of its kind.

It is therefore logically consistent that the Alumnae Association should honor this semi-centennial, and they are now making plans to that end and to enlist the sympathy and assistance of every graduate.

It is the purpose of the organization to place this letter in the hands of every member and to ask each recipient to extend the knowledge it contains to any and every graduate known to her even though not a member of the Alumnae Association.

It is earnestly hoped that all Boston City Hospital graduates will respond to any invitations or requests for help in making this celebration a pleasant and profitable occasion as well as a Memorial.

The dates as at present arranged are October 2, 3 and 4.

Keep them in mind and as far as possible make your own dates for vacation and other personal engagement for such times as will leave these days of early October free to foregather at the Boston City Hospital.

Faithfully yours,

MARY M. RIDDLE, R.N., *President*,
BOSTON CITY HOSPITAL NURSES' ALUMNAE ASSOCIATION.

January, 1928.

NEWS ITEMS

A PORTRAIT OF DR. JOHN W. FARLOW—The Boston Medical Library (8 The Fenway) is congratulating itself upon possessing a new acquisition in the form of an oil portrait of its former Librarian, Dr. John W. Farlow, who served the Library so very devotedly and efficiently for nearly twenty-five years. The portrait is the work of Mrs. Calvin G. Page, and those persons who have seen it consider it to be an excellent likeness of Dr. Farlow and a very clever piece of painting. It now hangs in Holmes Hall.

CONFERENCE ON CLINICAL THERMOMETERS—Recently the department accepted an invitation to send a delegate to a conference of manufacturers of clinical thermometers and master blank makers in New York City called by the United States Department of Commerce to consider establishing a commercial standard for clinical thermometers which may be used as a basis for the so-called "certification plan" recently put into operation by that department. If adopted, this would provide a general procedure under which nationally recognized specifications and methods of testing would be adopted for clinical thermometers so that physicians, hospitals and institutions could require manufacturers to certify in advance of purchase that clinical thermometers sold would meet these national tests.

The States of Connecticut and Massachusetts require thermometer manufacturers to be licensed, and test samples of the product from time to time. It was emphasized at the conference that other States are becoming the dumping ground for clinical thermometers that can not be sold in these two States.

A committee was appointed to voice objection to two bills recently introduced into the U. S. Congress that would require the actual testing in Washington of every clinical thermometer sold. Opposition was on the basis that ample funds are not provided to carry out this legislation and that accordingly great delays would ensue to purchasers of clinical thermometers, with resultant increase in cost of the thermometer.

POISON GAS NEUTRALIZER—Reports from Brussels convey the information that large sums of money have been supplied by public subscriptions headed by the King to support investigation in the development of a poison gas neutralizer.

The work is being conducted in The National University.

ABNORMAL PREVALENCE OF MENINGITIS IN 1927—The United States Public Health Service reports that there was an abnormal prevalence of spinal meningitis for the year 1927 as compared with the preceding two years. Thirty-seven States and the District of Columbia, having an estimated population of more than 90,000,000 reported 2,317 cases of meningococcus meningitis for the 49 weeks from January 2, 1927, to December 10, 1927; 1,571 cases for the corresponding period of 1926, and 1,226 cases for the 49 weeks in 1925.

COFFEE IS REGARDED AS BENEFICIAL—Professor Ralph H. Cheney of the biology department of the New York University is quoted as saying that "Evidence derived from my study of the effect of coffee on animals and man indicates that the properly prepared beverage is highly advantageous with respect to over 90 per cent. of normal individuals. . . . Caffeine is a drug and its use can be abused, but acute injury, as far as the caffeine content is concerned, would necessitate the consumption of over 150 cups which is of course, ridiculous." There must be recognized idfosyncrasies in the use of any article of diet.

HOSPITAL CONSTRUCTION IN NEW YORK CITY—New construction in hospitals in New York City has cost $45,700,000 in 1927. The largest part of this sum is represented by the plan of the New York Hospital—Cornell Medical College Association for a new medical centre on the East River to cost about $15,500,000.

Among other hospitals $5,000,000 has been expended for Lenox Hill, $2,500,000 for Lebanon, $2,000,000 for the Italian Hospital and $1,500,000 for St. Elizabeth's.

Ten Brooklyn projects are also included to the amount of $2,500,000 for the Jewish Hospital, $1,500,000 for the Methodist Episcopal, $1,500,000 for the Brooklyn Eye and Ear and $1,000,000 each for the Brownsville and East New York and St. Johns-Long Island. Several other large amounts are in contemplation for the building of additions.

DENTISTS FOR PUBLIC HEALTH—Surgeon General H. S. Cumming of the Public Health Service in an address recently delivered before the First District Dental Society of the State of New York urges dentists to recognize the opportunities for coöperation in public health measures. He stressed the fact that the relationhip between local, and especially focal, infections and systemic diseases has definitely given dentistry a permanent place in medical practice and in public health matters.

Dentistry may very properly be considered as a specialty of medicine and may take its place as an adjunct in medical departments.

CONTRIBUTIONS TO THE DIPHTHERIA CAMPAIGN—The Metropolitan Life Insurance Company has appropriated $10,000 for the the use in the State diphtheria prevention campaign in New York.

This contribution is to be used this year outside New York City in conjunction with the State Departments of Health and Education, the State Medical Society and the Metropolitan Company.

The Milbank Memorial Fund has also appropriated $85,338 to continue participation in the Cattaraugus County health demonstration during 1928 in association with $56,000 by the County Board of Health.

AN EXPENDITURE OF $1,100,000 BY THE HEALTH FUND—The Commonwealth Fund has spent $1,100,000 in 1927 to improve the physical and mental health of children according to the annual report recently published. This fund was established in 1918 with a gift of $10,000,000 from the late Mrs. Stephen V. Harkness.

Other contributions for hospitals, educational and welfare work brought a total of the year's expenditures to $1,953,557.

LEAD POISONING IN THE UNITED STATES—In an address before the Health Congress of the Royal Institute of Public Health at Ghent, Belgium, Dr. F. L. Hoffman reported that there had been a decline of 40 to 50 per cent. in chronic lead poisoning in this country during the last decade.

More cases are observed among painters with an annual mortality of about seventy persons in the United States, while lead workers furnish very few deaths, and the printing trade not over five persons.

Non-fatal cases among storage battery workers are frequent but few deaths from lead poisoning occur among these people.

Lead poisoning has occurred among person who use snuff because lead pigment, has been used to give color and weight. The Health Department of the City of New York has ordered this adulteration to be eliminated.

The reduction in the number of cases of lead poisoning is attributed to better living conditions and a decrease in the consumption of alcohol, shorter working hours and improved methods of personal hygiene.

DR. G. L. RICHARDS MARRIES MISS CHRISTINE MacLEAN—Dr. George L. Richards of 124 Franklin Street, Fall River, and Miss Christine M. MacLean were married February 7, 1928. Dr. and Mrs. Richards sailed for a trip abroad February 11th and will visit France, Norway, Sweden, and later Constantinople.

NOTICES

THE CELEBRATION OF THE FIRST ISSUE OF THE BOSTON MEDICAL AND SURGICAL JOURNAL

Gratifying responses to the invitation to attend the dinner at the Hotel Somerset, February 18, have been received.

There is still room for a limited number who may wish to attend.

The list of speakers is as follows:

Dr. Joseph Garland of Boston; Dr. Walter P. Bowers of Boston; Dr. Frederick Cheever Shattuck of Boston; Dr. E. W. Taylor, whose subject is "Personal Reminiscences and Comments"; Dr. Robert M. Green of Boston; Dr. David W. Parker of Manchester, N. H.; Dr. William G. Ricker of St. Johnsbury, Vt., and Dr. Morris Fishbein of Chicago, Ill., whose subject will be "Medical Journalism in the United States."

DELINQUENT DUES

Those members of the MASSACHUSETTS MEDICAL SOCIETY who have not paid their annual dues are reminded that this matter should be attended to before March 1st.

The Council has voted that the names of all members in arrears after March first are to be stricken from the mailing list of the JOURNAL.

UNITED STATES PUBLIC HEALTH SERVICE

CHRONOLOGICAL LIST OF CHANGES OF DUTIES AND STATIONS OF COMMISSIONED AND OTHER OFFICERS IN THE UNITED STATES PUBLIC HEALTH SERVICE.

JANUARY 18, 1928

Assistant Surgeon A. E. RUSSELL. Directed to proceed from Washington, D. C., to Richmond, Va., and return, for the purpose of taking part in the Institute for the training of tuberculosis workers, January 30 to Feb. 11, 1928. Jan. 11, 1928.

Surgeon C. V. AKIN. Directed to assume temporary charge of U. S. Quarantine Station, New Orleans, La., during absence of Medical Officer in Charge. Jan. 12, 1928.

Assistant Surgeon T. C. KIENZLE. Directed to proceed from New Orleans, La., to Charleston, S. C., without delay, and report to Commander Coast Guard Special Patrol Force, Charleston Navy Yard, for temporary duty. Jan. 12, 1928.

Passed Assistant Surgeon (R) C. B. DeFOREST. Ordered to active duty under terms of commission as Passed Assistant Surgeon in the Reserve Corps of the U. S. Public Health Service, effective January 16, 1928, and directed to report to the Medical Officer in Charge, U. S. Marine Hospital No. 1, Baltimore, Md., for duty. Jan. 12, 1928.

A. A. Surgeon LOUIS E. McCANNA. Relieved from duty Mobile, Ala., and assigned to duty at the Baltimore Quarantine Station, Baltimore, Md., stopping enroute at Washington, D. C., for conference. Jan. 12, 1928.

Surgeon GROVER A. KEMPF. Directed to proceed from Washington, D. C., to Hagerstown, Md., and return, in connection with field investigations in child hygiene carried on by the Public Health Service. Jan. 12, 1928.

Surgeon G. C. LAKE. Directed to proceed from Stapleton, N. Y., to Washington, D. C., and return, in connection with venereal disease control. Jan. 12, 1928.

Surgeon J. H. LINSON. Directed to proceed from Chicago, Ill., to Aledo, Illinois, to investigate case for U. S. Employees' Compensation Commission. Jan. 13, 1928.

Surgeon J. G. WILSON. Directed to proceed from El Paso, Tex., to Columbus, New Mexico, and return, for the purpose of conferring with Acting Assistant Surgeon S. S. Warren, relative to quarantine and immigration matters at that port. Jan. 13, 1928.

A. A. Surgeon F. M. EVANS. Relieved from duty at Mobile, Alabama, and assigned to duty at the U. S. Quarantine Station, Baltimore, Md. Jan. 13, 1928.

Assistant Surgeon ALBERT E. RUSSELL. Directed to proceed from Washington, D. C., to such places as may be necessary in the State of South Carolina, and return, during the month of January, 1928, in connection with dust studies. Jan. 13, 1928.

Surgeon G. W. McCOY. Directed to proceed from Washington, D. C., to Chicago, Ill., and return, to attend the Annual Congress on Medical Education, Licensure and Hospitals, American Medical Association, Feb. 6-8. Jan. 13, 1928.

Assistant Surgeon J. F. VAN ACKEREN. Directed to proceed from New Orleans, La., to Charleston, S. C., and report to Commander Coast Guard Special Patrol Force, Charleston Navy Yard, for temporary duty. Jan. 13, 1928.

A. A. Surgeon C. F. COSTENBADER. Directed to proceed from Greenville, S. C., to such places in the State of South Carolina, as may be necessary, and return, in connection with dust studies. Jan. 13, 1928.

Assistant Surgeon General F. C. SMITH. Directed to proceed from Washington, D. C., to New York, N. Y., and return, to confer with the District Director, regarding administration work in his district. Jan. 14, 1928.

Special Consultant JAY F. SCHAMBERG. Directed to proceed from Philadelphia, Pa., to Hot Springs, Ark., and return, in connection with venereal disease control measures. Jan. 14, 1928.

Associate Sanitary Engineer LEONARD GREENBURG. Directed to proceed from New Haven, Conn., to Greenville, S. C., stopping enroute at Pittsburgh, Pa., and Washington, D. C., in connection with the dust studies being conducted by the Office of Industrial Hygiene and Sanitation. Jan. 14, 1928.

Surgeon NORMAN ROBERTS. Relieved from duty at Washington, D. C., and assigned to duty at Ellis Island, N. Y. Jan. 14, 1928.

Assistant Surgeon J. B. RYON. Relieved from duty at Ellis Island, N. Y., and assigned to duty at M. H. No. 70, New York, N. Y. Jan. 14, 1928.

Surgeon C. E. WALLER Upon completion of duties in New Orleans, La., directed to proceed to points in Mississippi, Tennessee, Louisiana and Arkansas, as may be necessary in connection with the prevention and suppression of the spread of epidemic diseases in the flood area. Jan. 16, 1928.

Sanitary Engineer LESLIE C. FRANK. Directed to proceed from Washington, D. C., to Baltimore, Md., to confer with health officials regarding milk investigations. Jan. 16, 1928.

Associate Sanitary Engineer A. P. MILLER. Directed to proceed from Washington, D. C., to New York, N. Y., and return, for conference with Associate Sanitary Engineer E. C. Sullivan, regarding the revision and administration of the Interstate Quarantine Regulations. Jan. 16, 1928.

Assistant Surgeon General W. F. DRAPER. Directed to proceed from Washington, D. C., to New York, N. Y., and return for the purpose of conferring with members of the International Health Board concerning the work in connection with the prevention and suppression of epidemic diseases in the Mississippi Flood area. Jan. 16, 1928.

A. A. Surgeon E. BLANCHE STERLING. Directed to proceed from Washington, D. C., to Baltimore, Md., and return, for special conference relating to child hygiene work. Jan. 16, 1928.

Surgeon W. L. TREADWAY. Directed to proceed from Dublin, Irish Free State, to Warsaw, Poland, and such other points in Europe, as may be necessary, and return, where medical examinations of aliens are being conducted. Jan. 16, 1928.

Administrative Assistant W. C. BRYANT. Relieved from duty at M. H. No. 2, Boston, Mass., and assigned to duty at M. H. No. 16, Portland, Maine. Jan. 16, 1928.

Administrative Assistant WALTER LEWIS. Relieved from duty at Portland, Maine, and assigned to duty at Malaria Investigation Field Headquarters, Richmond, Va. Jan. 16, 1928.

Administrative Assistant D. W. BISHOP. Relieved from duty at Richmond, Va., and assigned to duty at M. H. No. 2, Boston, Mass. Jan. 16, 1928.

Passed Assistant Surgeon (R) C. B. DEFOREST. Relieved from duty at Baltimore, Md. ,and assigned to duty at M. H. No. 13, Mobile, Ala. Jan. 16, 1928.

Assistant Surgeon General F. A. CARMELIA. Directed to proceed from Washington, D. C., to Milford, Delaware, and return, for the purpose of making an inspection of the new quarantine diesel tug under construction at that place for the Public Health Service. Jan. 17, 1928.

BOARDS CONVENED

Boards convened at the following places to examine officers of the Coast Guard for promotion:

San Francisco, Cal., Jan. 24, 1928. Detail for board: Surgeon R. H. Creel, Surgeon J. F. Worley.

Boston, Mass., call of chairman. Detail for board: P. A. Surgeon (R) W. E. McLellan, Asst. Surgeon L. J. Hand.

H. S. CUMMING, *Surgeon General.*

REPORTS AND NOTICES OF MEETINGS

MEETING OF THE MASSACHUSETTS MEDICO-LEGAL SOCIETY

The Massachusetts Medico-Legal Society held a stated meeting on Wednesday afternoon, Feb. 1st, 1928, at 2:30 o'clock in the Warren Anatomical Museum at the Harvard Medical School. Dr. E. L. Hunt, president, in the chair, brought the attention of the members to House Bill 493, now pending in the Massachusetts Legislature, providing that medical examiners be restricted from testifying before industrial boards except by invitation. The Society went on record as not approving the bill. It was decided that the next meeting would take place at Worcester, Mass., in June.

The first paper, entitled "A Suggested Expansion of the Medical Examiner's Functions," was presented by E. M. Morgan, Professor of Law in Harvard University. Prof. Morgan first considered the coroner system as it now exists in many American cities. In ancient days the coroner was an officer of the crown and was confronted with problems less in tricate than those of the present time. With the increasing complexity of life the coroner was in no sense fitted to determine with scientific accuracy the pathological cause of death. Not only was the office of coroner made a political plaything, but the coroner, once elected, was burdened with duties which had no connection with the proper determination of the cause of death.

In contrast to the condition which exists in New Orleans, San Francisco, and Chicago, Prof. Morgan pointed out New York and Boston which are under the medical examiner system. Here there is a coöperation between the medical examiner's office, the police and the district attorney. The testimony of the medical examiner is considered a truthful account of the findings, unbiased by political atmosphere or by insufficient examination.

On the basis of these findings Prof. Morgan proposed that the function of the medical examiner's office be tremendously expanded. He suggested the prompt coöperation of toxicologist, microscopist, bacteriologist, etc., in the proper application of criminal justice. It may be argued that there are so many rules of law in irreconcilable conflict with modern medical opinion, that to enlarge the scope of the medical examiner's office would be useless. On the other hand, information acquired by the medical examiner may be of use to the police in an early investigation.

Prof. Morgan then discussed the conflicts between

the medical and legal theories. They certainly disagree upon the question of disposition of the mentally incompetent offender. The medical man wants to know what the mental condition of the accused is and its relation to his anti-social conduct. The court questions whether the accused committed the act and what effect his mental condition should have upon society's attitude towards him. The question of insanity, irresistible impulse, and momentary loss of sanity has been raised often recently. Whether these pleas are to be considered or whether the tests of the medical profession are to be final is a problem which only further study can solve. It seems reasonably clear, then, that the suggested expansion of the medical examiner's office would speed the day when the medical and legal professions would create harmony in the treatment of an accused person.

Dr. G. B. MacGrath stated at the conclusion of Prof. Morgan's paper that while approving the suggestion he did not believe in adding many more assistants to the office of the medical examiner. He contended that the duties of the examiner should not be too diversified.

The second paper entitled "Why a Medico-Legal Society," was presented by Dr. C. W. Skelton, President of the Rhode Island Medico-Legal Society. Dr. Skelton gave a resumé of the inefficient coroner system as it exists in Rhode Island. By comparison with the system of Massachusetts he showed the evident advantages of the medical examiner system. The role of a medico-legal society in bringing about a change in this coroner system and thereby a change in public morals and welfare, and in the furnishing of expert testimony is one not to be lightly disregarded.

The meeting which celebrated the Golden Anniversary of the founding of the society was attended by some thirty members and guests.

MEETING OF THE BELMONT MEDICAL CLUB

This Club met with Dr. W. C. Hanson on February 9, 1928, and adopted a fee table in conformity with the custom among towns in that vicinity.

Regular meetings of the Club will be held on the fourth Friday of each month. Dr. F. J. Cotton will read a paper at the next meeting.

A MEETING OF THE ALUMNI ASSOCIATION OF THE MIDDLESEX COLLEGE OF MEDICINE AND SURGERY

This meeting was held recently at the Hotel Statler. Dr. T. V. Campagna, President of the Association, presented Dr. H. S. Card as toastmaster. Addresses were made by Dr. R. S. York and Mr. Joseph Hurley. Especial interest was centered in the information that the College has recently purchased a 93-acre tract of land in Waltham upon which medical and other buildings for scientific work will be erected.

MEETING OF THE BOSTON TUBERCULOSIS ASSOCIATION

At this meeting recently the following officers were elected: President, Dr. John B. Hawes, 2d; Vice-President, Dr. James J. Minot; Treasurer, George S. Mumford; Clerk, Miss Isabel F. Hyams.

The executive committee includes: Dr. Hawes, chairman; Dr. Cleaveland Floyd, Dr. George S. Hill, Miss Hyams, Dr. Harry Linenthal, Henry C. McKenna, Dr. Minot, Dr. Frederic Lord, Mr. Mumford, Dr. Edward O. Otis, Miss Julia C. Prendergast, Miss Lillian V. Robinson, Mrs. Reginald Heber White, Raymond S. Wilkins and Ralph May.

MEETING OF NORTH SHORE BABIES' HOSPITAL IN SALEM

Dr. L. L. Kelley of Peabody was elected as President of this organization recently to succeed Dr. W. G. Phippen, who resigned. Dr. J. G. Corcoran of Hamilton is Staff Secretary. Other members are Drs. C. F. Deering of Danvers, R. C. Stickney of Beverly and J. F. Donaldson of Salem. The Staff meets monthly.

THE AMERICAN DOCTORS CLINIC AND GOLF ASSOCIATION

Committee of Arrangements. (Permanent Officers of the Club will be elected on the Steamer.) John P. DeWitt, M.D., 112 Shore Avenue, Canton, Ohio; M. M. Cullom, M.D., Nashville, Tenn.; S. A. Mahoney, M.D., Holyoke, Mass.; J. L. Smith, M.D., Secy., 2312 No. Sawyer Avenue, Chicago.

To combine with the opportunity given by a European trip organized for clinical study and the sight-seeing incident to it, the pleasure of meeting and playing golf on some of the renowned links of the Old World, the above named association of Doctors has worked out a summer vacation tour for 1928 to sail from New York the first week in July on the White Star Line Steamer Adriatic and to visit Liverpool, Leeds, Edinburgh, Birmingham, the Shakespeare country, London, Brussels, Ostend, Paris, the Battlefields, with a return to Montreal from Cherbourg August 16, reaching that city the twenty-third.

The Pratt Tours, Canadian Pacific Railway Office, Chicago, will look after the sight-seeing, railways, steamships, hotels, and details of the Tour in Europe.

J. L. Smith, M.D., 2312 North Sawyer Avenue, Chicago, who has run several very successful Old World Tours for clinical instruction, and to visit the hospitals of Europe, will have charge of all clinical arrangements.

The Program of the golfers is now being worked out with the Association and management of different Courses in Europe.

We plan to include Hoylake, Gleneagles, St. Andrews, Finham Park, Sandy Lodge, and many of the famous Courses adjacent to the towns and cities along our route. It is on our contemplated Program also to arrange frequent matches between our own Doctors and, when possible, with members of the English and Scotch Clubs visited.

Make your reservations as early as possible, that we may take good care of you. Write for Steamer Room, complete Program, etc., and let us know if you will probably go.

JAMES L. SMITH, M.D., *Sec.*

UNION HOSPITAL IN FALL RIVER

CLINICAL STAFF MEETING

The Regular Monthly Clinical Staff Meeting is scheduled for Thursday, February 16, 1928, at 8:15 P. M., at the Stevens Clinic.

M. N. TENNIS, M.D.,
Secretary to Staff.

SOUTH END NEIGHBORHOOD MEDICAL CLUB

The next monthly meeting of the South End Neighborhood Medical Club will be held at the office of the Boston Tuberculosis Association, 554 Columbus Avenue, Boston, on Tuesday, February 21, 1928, at 12 noon.

The speaker will be Dr. Channing Frothingham, Assistant Professor at the Harvard Medical School, and Visiting Physician, Peter Bent Brigham Hospital, who will talk on "Nephritis". All physicians are cordially invited.

Following the meeting luncheon will be served.

THE CONVENTION OF THE CATHOLIC HOSPITAL ASSOCIATION

The 13th Annual Convention of the Catholic Hospital Association of the United States and Canada and the Second Annual Hospital Clinical Congress of North America will be held in the Cincinnati Music Hall, Cincinnati, Ohio, June 18th to 22nd, inclusive, 1928. The Fourth Annual Convention of the International Guild of Nurses will be held at the same time, in the same building, at night meetings.

This Convention and Congress will be one of the largest and most important hospital meetings of the year, and will comprise general scientific meetings, special clinics or demonstrations of hospital departments, and three hundred special commercial and educational exhibits. Outstanding authorities in medicine, surgery, pathology, nursing, dietetics and hospital administration, architecture and engineering will lecture and demonstrate in specially planned clinics representing the various departments of the modern hospital. A professional program of the highest interest and value is now being formulated, and all persons interested in medical and hospital service are cordially invited to attend. Further information may be obtained from John R. Hughes, M.D., Dean of the College of Hospital Administration, Marquette University, Milwaukee, Wisconsin, who is General Chairman of the Convention and Congress.

SOCIETY MEETINGS

February 16—Clinical Staff Meeting, Union Hospital in Fall River. Complete notice appears on page 1596, this issue.

February 17—Massachusetts Psychiatric Society. For detailed notice see page 1535, issue of February 9.

February 21—South End Neighborhood Medical Club. Detailed notice appears elsewhere on this page.

February 24—Belmont Medical Club. Complete notice appears on page 1596, this issue.

March 3—Annual meeting of the American Society for the Control of Cancer. Detailed notice appears on page 1535, issue of February 9.

March 13, April 10—Massachusetts Dietetic Association. For complete notice see page 1535, issue of February 9.

June 18-22—Convention of the Catholic Hospital Association. Complete notice appears above.

DISTRICT MEDICAL SOCIETIES

Essex North District Medical Society

May 2, 1928 (Wednesday)—Annual meeting at Haverhill, 12:30 P. M., at the Haverhill Country Club, Brickett Hill, Gile Street, Haverhill.

May 3, 1928 (Thursday)—Censors meet for examination of candidates at Hotel Bartlett, 95 Main Street, Haverhill, at 2 P. M. Candidates should apply to the Secretary, J. Forrest Burnham, M.D., 567 Haverhill Street, Lawrence, at least one week prior.

Essex South District Medical Society

March 7 (Wednesday)—Lynn Hospital. Clinic at 5 P. M. Dinner at 7 P. M.

Dr. Henry R. Viets, "The Acute Infections of the Nervous System," with lantern slides and moving pictures.

Discussion by Dr. W. V. McDermott of Salem and J. W. Trask of Lynn, 10 minutes each, and from the floor.

April 11 (Wednesday)—Essex Sanatorium, Middleton. Clinic at 5 P. M. Dinner at 7 P. M.

Dr. Raymond S. Titus, "Obstetrical Emergencies."

Discussion by Drs. J. J. Egan of Gloucester and A. T. Hawes of Lynn, 10 minutes each, and from the floor.

May 3 (Thursday)—Censors meet at Salem Hospital for the examination of candidates at 3:30 P. M. Candidates should apply to the Secretary, Dr. R. E. Stone, Beverly, at least one week prior.

May 8 (Tuesday)—Annual meeting. Detailed notice appears on page 1437, issue of January 26.

Norfolk District Medical Society

February 29—Roxbury Masonic Temple. Orthopedics in General Practice. Dr. Paul N. Jepson.

March 27—Meeting at the Norwood Hospital. Presentation of paper or cases from members of the District.

May 3—Censors' meeting. Roxbury Masonic Temple, 4 P. M. Applications will be mailed by the Secretary upon request.

May 8—Annual meeting. Details to be announced.

Suffolk District Medical Society

Combined meetings of the Suffolk District Medical Society and the Boston Medical Library will be held at the Boston Medical Library, 8 The Fenway, at 8:15 P. M., as follows:

February 29—Surgical Section. Subject to be announced later.

March 28—Medical Section. "The Use and Misuse of Vaccines." Dr. Hans Zinsser, Dr. Francis M. Rackemann, Dr. Charles H. Lawrence.

April 25—Annual meeting. Election of officers. Paper of the evening to be announced later.

The medical profession is cordially invited to attend these meetings.

Notices of meetings must reach the JOURNAL office on the Friday preceding the date of issue in which they are to appear.

BOOK REVIEWS

The Tongue and Its Diseases. By DUNCAN C. L. FITZWILLIAMS. Oxford University Press, 1927.

The author has picked a subject on which very few books have been written. Neither the laryngologist nor the general surgeon feels inclined to claim patients with diseases of the tongue, hence these patients are apt to be passed about without getting relief.

One would hardly expect that 498 pages could be written about the tongue, nor could they unless the author had mastered his subject as this one has. The preliminary chapters deal with the anatomy, normal development and abnormalities of development. The usual and unusual diseases are dealt with according to their importance.

A large section of the volume deals with precancerous conditions and cancer. The types of operative procedures including diathermy are discussed. The author does not believe diathermy has any merit. He mentions various methods of application of radium, the use of colloidal lead.

Considerable attention is given to the palliative treatment of diseases of the tongue.

Tobacco and Physical Efficiency. A Digest of Clinical Data (with Annotated Bibliography). By PIERRE SCHRUMPF-PIERRON, M.D., Professor of Clinical Medicine, University of Cairo. Published under the Auspices of The Committee to Study the Tobacco Problem. Paul B. Hoeber, Inc., Publishers, 76 Fifth Avenue, New York.

This little book, as the foreword by Dr. Alexander Lambert, President of the Committee, states, does not give the results of original scientific investigations, but is rather "a succinct summary of the literature, accompanied by an extended annotated bibliography."

One of the most striking impressions left by a reading of Professor Schrumpf-Pierron's work is that it is no biassed attempt on the part of an antinicotine crank to condemn the tobacco evil. Rather

it is apparently a sincere and fair-minded effort properly to evaluate the mass of work that has been done on the subject and to aid in arriving at a sincere conclusion regarding the known and possible evils of the drug.

Various chapters take up the chemical constituents and pharmacological action of tobacco; its action on the nervous system, the circulatory system, the respiratory system, the digestive system, and the genitourinary system; its action on the skin; nicotinism associated with other kinds of poisoning; effect of tobacco on growth; tobacco poisoning in tobacco workers; the disinfecting power of tobacco and the psychological effect of nicotinism.

The conclusions are sound: the study is still incomplete, but it is evident that the immoderate use of tobacco may bring on disturbances which are just functional and then organic.

An extensive bibliography is appended.

Diseases of the Heart. By FREDERICK W. PRICE. Oxford University Press—Second Edition, 1927.

This is a 500-page volume written in a fairly readable style. The book covers all phases of heart disease, taking up a discussion of the clinical features as well as polygraphy and electrocardiography. It is essentially meant for clinical use. It has been brought up to this present year, as some very recent references in the literature are included. In general, one can find some reference to any of the ordinary questions that come up in the diagnosis, prognosis and treatment of heart disease. Most of it is very soundly expressed, although in some matters one might well take a different point of view from that expressed by the author. On page 217, in discussing pulsus alternans, the author states, "In the great majority of cases, it is necessary to take a tracing of the radial artery to recognize the condition." This we now know is not true, for in most cases the condition can be recognized with a sphygmomanometer while taking the blood pressure of the patient.

Likewise in discussing the differential diagnosis between bacterial endocarditis and rheumatic endocarditis, no mention is made of finding an enlarged spleen by palpation, or of clubbing of the fingers as important aids. It is also to be regretted that the book contains no satisfactory clinical account of the picture of coronary thrombosis as it is now well recognized. Altogether, with a few omissions, the book covers the subject it takes up fairly satisfactorily.

Blood Pressure—Its Clinical Applications. NORRIS-BAZETT-MCMILLAN. Published by Lea & Febiger Company. Price $4.50. 4th Edition.

An unusual book, which though narrow in title is broad in clinical usefulness. The many ramifications of blood pressure in clinical and experimental medicine are welded together into an orderly treatise with such breadth of clinical vision that an astonishingly valuable book on therapeusis is the result. The first five chapters deal chiefly with the basic physical and physiological principles underlying blood pressure, but even in this theoretical section are gleanings of great clinical value. The remaining fifteen chapters deal almost entirely with the clinical importance of blood pressure. There is an unusually excellent chapter on hypotension. Other chapters consider the blood pressure in infectious disease, cardiac disease, arteriosclerosis and diseases of the endocrine glands. Five chapters are devoted to hypertension and a more satisfactory consideration of its classification, etiology, symptomatology, treatment and prognosis could not be asked for. Special chapters dealing with the blood pressure in diseases of the central nervous system, in surgery, in obstetrics and in ophthalmology are written by Francis G. Grant, George P. Müller, Norris Wister Vaux and Hunter W. Scarlett, respectively.

The book is well arranged, the paragraph headings are excellent and the index is good, which factors facilitate quick and easy reference.

Surgery of Neoplastic Diseases by Electrothermic Methods. By GEORGE A. WYETH, M.D. 316 pages, $7.50. Paul B. Hoeber, Inc., New York.

In this book the principles of the operative treatment of superficial and deep tumors, blemishes, skin lesions, etc., by electrothermic methods are outlined. A high frequency current is used and since all the heat used for the destruction of the lesion is developed within the tissues "endothermy" has been coined to describe the method.

For superficial lesions a monopolar current is used and the process is known as desiccation. For deeper lesions a bipolar current, also known as diathermy, is used. Coagulation of a lesion or the area around the lesion may be accomplished with a minimum of bleeding. A damped high frequency current is used. The technique of using this apparatus is described in detail.

The endotherm knife is an active electrode, which in the presence of an undamped high frequency current produces such rapid disintegration of cells that it passes through tissues with the speed of a knife. Tumors that would usually be considered inoperable can be safely removed with very little bleeding and with complete sealing off of the lymphatics.

This procedure is a great addition to the agencies already being used for the treatment of malignant disease. Much of the material given in this book is the original work of the author.

X-Rays and Radium in the Treatment of Diseases of the Skin. By GEORGE M. MACKEE, Philadelphia. Lea & Febiger. 788 pages.

This book in its second edition presents the last word in the use of these agents in the treatment of skin diseases. The general scheme of the first edition is preserved subject to much revision and the addition of new material.

Half of the book is devoted to the technical side of X-ray and radium. The historical phase of their development is presented and detailed descriptions of modern X-ray apparatus and radium applicators and the mechanics of their use are given. New chapters on spectroscopy, ionization methods of measurement and long wave length roentgen therapy have been added.

The revision includes the treatment of a dozen new diseases and the text has been improved by the addition of many new tables and over a hundred illustrations.

Dr. McKee is an enthusiastic worker in this field of therapy who believes that X-rays "contribute the most important single therapeutic agent in the armamentarium of pure dermatology." So it is not surprising to find many conditions treated by X-ray that would respond equally well to other agents, and probably better, even in the hands of most dermatologists. That the path of the X-ray or radium workers in this field is not without its costly pitfalls is evinced by a splendidly practical chapter on the medico-legal relations of this therapy, which is not without its practical application to every physician. The book, which is thoroughly interesting, convincing and readable, can be used with profit by anyone employing X-ray and radium in diseases of the skin.

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